

A NONSUBSTANTIVE REVISION  
OF STATUTES RELATING TO  
INSURANCE FEES AND TAXES, CONSUMER INTERESTS,  
HEALTH INSURANCE AND RELATED PRODUCTS, TITLE INSURANCE,  
AND INSURANCE INDUSTRY PROFESSIONALS

Submitted to the 78th Legislature  
as part of the  
Texas Legislative Council's  
Statutory Revision Program

Austin, Texas

2003

"November 10, 1981," for the quoted language.

Revisor's Note  
(End of Chapter)

Section 1, V.T.I.C. Article 3.51-9, states the purpose of that article. The revised law omits the provision as unnecessary because it is nonsubstantive and because the legislative purpose in enacting the article is clear from the other, substantive provisions of the article revised in this chapter. The omitted law reads:

Art. 3.51-9

Sec. 1. The purpose of this article is to provide consumers with benefits for the care and treatment of chemical dependency in group health insurance policies or contracts, group health coverage provided by health maintenance organizations, and all self-funded or self-insured plans (but excluding those self-funded or self-insured plans with 250 or fewer employees or members), that provide basic hospital, surgical, or major medical expense benefits or coverages or any combination of these coverages, but excluding all individual insurance policies, and any individual H.M.O. policies, regardless of the method of solicitation or sale, and excluding all health insurance policies that only provide cash indemnity for hospital or other confinement benefits, or supplemental or limited benefit coverage, or coverage for specified diseases or accidents, or disability income coverage, or any combination thereof.

CHAPTER 1369. BENEFITS RELATED TO PRESCRIPTION DRUGS  
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1 CHAPTER 1369. BENEFITS RELATED TO PRESCRIPTION DRUGS  
2 AND DEVICES AND RELATED SERVICES  
3 SUBCHAPTER A. COVERAGE OF PRESCRIPTION DRUGS IN GENERAL

4 Revised Law

5 Sec. 1369.001. DEFINITIONS. In this subchapter:

6 (1) "Contraindication" means the potential for, or the  
7 occurrence of:

8 (A) an undesirable change in the therapeutic  
9 effect of a prescribed drug because of the presence of a disease  
10 condition in the patient for whom the drug is prescribed; or

11 (B) a clinically significant adverse effect of a  
12 prescribed drug on a disease condition of the patient for whom the  
13 drug is prescribed.

14 (2) "Drug" has the meaning assigned by Section  
15 551.003, Occupations Code.

16 (3) "Indication" means a symptom, cause, or occurrence  
17 in a disease that points out the cause, diagnosis, course of  
18 treatment, or prognosis of the disease.

19 (4) "Peer-reviewed medical literature" means  
20 scientific studies published in a peer-reviewed national  
21 professional journal. (V.T.I.C. Art. 21.53M, Secs. 1(1), (2), (4),  
22 (5).)

23 Source Law

24 Art. 21.53M

25 Sec. 1. In this article:

26 (1) "Contraindication" means the  
27 potential for, or the occurrence of, an undesirable  
28 alteration of the therapeutic effect of a prescribed  
29 drug prescription because of the presence, in the  
30 patient for whom it is prescribed, of a disease  
31 condition, or the potential for, or the occurrence of,  
32 a clinically significant adverse effect of the drug on  
33 the patient's disease condition.

34 (2) "Drug" has the meaning assigned by  
35 Section 5, Texas Pharmacy Act (Article 4542a-1,  
36 Vernon's Texas Civil Statutes).

37 (4) "Indication" means any symptom, cause,  
38 or occurrence in a disease that points out the cause,  
39 diagnosis, course of treatment, or prognosis of the  
40 disease.

41 (5) "Peer-reviewed medical literature"  
42 means published scientific studies in any  
43 peer-reviewed national professional journal.

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(1) Section 1(2), V.T.I.C. Article 21.53M, s to Section 5, Texas Pharmacy Act (Article -1, Vernon's Texas Civil Statutes). That statute modified in 1999 as Section 551.003, Occupations The revised law is drafted accordingly.

(2) Section 1(3), V.T.I.C. Article 21.53M es "health benefit plan." The revised law omits definition as unnecessary because Section 2 of article, revised as Sections 1369.002 and 003, specifies the types of health benefit plans which this subchapter applies, and thus the defined is not helpful to the reader. The omitted law :

(3) "Health benefit plan" means a plan described by Section 2 of this article.

Revised Law

1369.002. APPLICABILITY OF SUBCHAPTER.

applies only to a health benefit plan that pr r medical or surgical expenses incurred as a resu ition, accident, or sickness, including an indiv nket, or franchise insurance policy or ins a group hospital service contract, or an individ nce of coverage or similar coverage document t

(1) an insurance company;

(2) a group hospital service corporation ope r 842;

(3) a fraternal benefit society operating

(4) a stipulated premium company operating

(5) a reciprocal exchange operating under Chapte

(6) a health maintenance organization operating

(2) Section 1(3), V.T.I.C. Article 21.53M, defines "health benefit plan." The revised law omits this definition as unnecessary because Section 2 of this article, revised as Sections 1369.002 and 1369.003, specifies the types of health benefit plans to which this subchapter applies, and thus the definition is not helpful to the reader. The omitted law reads:

(3) "Health benefit plan" means a plan described by Section 2 of this article.

Revised Law

1369.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides for medical or surgical expenses incurred as a result of illness, accident, or sickness, including an individual policy, contract, or franchise insurance policy or insurance contract, a group hospital service contract, or an individual certificate of coverage or similar coverage document to which the insured is entitled.

(1) an insurance company;

(2) a group hospital service corporation operating under chapter 842;

(3) a fraternal benefit society operating under chapter 842;

(4) a stipulated premium company operating under chapter 842;

(5) a reciprocal exchange operating under chapter 842;

(6) a health maintenance organization operating under chapter 842.

(3) "Health benefit plan" means as described by Section 2 of this chapter.

Revised Law

APPLICABILITY OF SUBCHAPTER 10-100 TO A HEALTH BENEFIT PLAN THAT PROVIDES COVERAGE FOR MEDICAL OR SURGICAL EXPENSES INCURRED AS A RESULT OF AN ACCIDENT, OR SICKNESS, INCLUDING AN ACCIDENT OR SICKNESS WHILE COVERED UNDER A FRANCHISE INSURANCE POLICY OR A HOSPITAL SERVICE CONTRACT, OR AN INSURANCE POLICY, RENTAL CARRENTAGE OR SIMILAR COVERAGE DOCUMENT ISSUED BY AN INSURANCE COMPANY;

GROUP HOSPITAL SERVICE CORPORATION;

INTERNAL BENEFIT SOCIETY OPERATING UNDER A BENEFIT PLAN;

POPULATED PREMIUM COMPANY OPERATING UNDER A BENEFIT PLAN;

RECIPROCAL EXCHANGE OPERATING UNDER A BENEFIT PLAN;

HEALTH MAINTENANCE ORGANIZATION OPERATING UNDER A BENEFIT PLAN;

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Sec. 1369.002. APPLICABILITY OF SUBCHAPTER. This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a condition, accident, or sickness, including an individual, blanket, or franchise insurance policy or insurance contract, a group hospital service contract, or an individual or evidence of coverage or similar coverage document that is provided by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a reciprocal exchange operating under Chapter 942;
- (6) a health maintenance organization operating under Chapter 943.

- (1) an insurance company;
- (2) a group hospital service corporation operating under 842;
- (3) a fraternal benefit society operating under 842;
- (4) a stipulated premium company operating under 842;
- (5) a reciprocal exchange operating under Chapter 942;
- (6) a health maintenance organization operating under 842;

Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53M, Sec. 2(a).)

#### Source Law

Sec. 2. (a) This article applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 20 of this code;
- (3) a fraternal benefit society operating under Chapter 10 of this code;
- (4) a stipulated premium insurance company operating under Chapter 22 of this code;
- (5) a reciprocal exchange operating under Chapter 19 of this code;
- (6) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or
- (8) an approved nonprofit health corporation that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

#### Revisor's Note

Section 2(a)(8), V.T.I.C. Article 21.53M, refers to an approved nonprofit health corporation that holds a certificate of authority "issued by the commissioner." The revised law omits the quoted language as unnecessary because Article 21.52F, revised as Chapter 844 of this code, requires the commissioner to issue the certificate of authority.

#### Revised Law

Sec. 1369.003. EXCEPTION. This subchapter does not apply to:

- (1) a health benefit plan that provides coverage:

1 (A) only for a specified disease or for another  
2 limited benefit;

3 (B) only for accidental death or dismemberment;

4 (C) for wages or payments in lieu of wages for a  
5 period during which an employee is absent from work because of  
6 sickness or injury;

7 (D) as a supplement to a liability insurance  
8 policy;

9 (E) for credit insurance;

10 (F) only for dental or vision care;

11 (G) only for hospital expenses; or

12 (H) only for indemnity for hospital confinement;

13 (2) a small employer health benefit plan written under  
14 Chapter 1501;

15 (3) a Medicare supplemental policy as defined by  
16 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),  
17 as amended;

18 (4) a workers' compensation insurance policy;

19 (5) medical payment insurance coverage provided under  
20 a motor vehicle insurance policy; or

21 (6) a long-term care insurance policy, including a  
22 nursing home fixed indemnity policy, unless the commissioner  
23 determines that the policy provides benefit coverage so  
24 comprehensive that the policy is a health benefit plan as described  
25 by Section 1369.002. (V.T.I.C. Art. 21.53M, Sec. 2(b).)

26 Source Law

27 (b) This article does not apply to:

28 (1) a plan that provides coverage:

29 (A) only for a specified disease or  
30 other limited benefit;

31 (B) only for accidental death or  
32 dismemberment;

33 (C) for wages or payments in lieu of  
34 wages for a period during which an employee is absent  
35 from work because of sickness or injury;

36 (D) as a supplement to liability  
37 insurance;

38 (E) for credit insurance;

39 (F) only for dental or vision care;

40 (G) only for hospital expenses; or

41 (H) only for indemnity for hospital

1 confinement;

2 (2) a small employer health benefit plan  
3 written under Chapter 26 of this code;

4 (3) a Medicare supplemental policy as  
5 defined by Section 1882(g)(1), Social Security Act (42  
6 U.S.C. Section 1395ss), as amended;

7 (4) workers' compensation insurance  
8 coverage;

9 (5) medical payment insurance coverage  
10 issued as part of a motor vehicle insurance policy; or

11 (6) a long-term care policy, including a  
12 nursing home fixed indemnity policy, unless the  
13 commissioner determines that the policy provides  
14 benefit coverage so comprehensive that the policy is a  
15 health benefit plan as described by Subsection (a) of  
16 this section.

17 Revised Law

18 Sec. 1369.004. COVERAGE REQUIRED. (a) A health benefit  
19 plan that covers drugs must cover any drug prescribed to treat an  
20 enrollee for a chronic, disabling, or life-threatening illness  
21 covered under the plan if the drug:

22 (1) has been approved by the United States Food and  
23 Drug Administration for at least one indication; and

24 (2) is recognized by the following for treatment of  
25 the indication for which the drug is prescribed:

26 (A) a prescription drug reference compendium  
27 approved by the commissioner for purposes of this section; or

28 (B) substantially accepted peer-reviewed medical  
29 literature.

30 (b) Coverage of a drug required under Subsection (a) must  
31 include coverage of medically necessary services associated with  
32 the administration of the drug.

33 (c) A health benefit plan issuer may not, based on a  
34 "medical necessity" requirement, deny coverage of a drug required  
35 under Subsection (a) unless the reason for the denial is unrelated  
36 to the legal status of the drug use.

37 (d) This section does not require a health benefit plan to  
38 cover:

39 (1) experimental drugs that are not otherwise approved  
40 for an indication by the United States Food and Drug  
41 Administration;

42 (2) any disease or condition that is excluded from

1 coverage under the plan; or

2 (3) a drug that the United States Food and Drug  
3 Administration has determined to be contraindicated for treatment  
4 of the current indication. (V.T.I.C. Art. 21.53M, Sec. 3.)

5 Source Law

6 Sec. 3. (a) A health benefit plan that  
7 provides coverage for drugs must provide coverage for  
8 any drug prescribed to treat an enrollee for a covered  
9 chronic, disabling, or life-threatening illness if the  
10 drug:

11 (1) has been approved by the Food and Drug  
12 Administration for at least one indication; and

13 (2) is recognized for treatment of the  
14 indication for which the drug is prescribed in:

15 (A) a prescription drug reference  
16 compendium approved by the commissioner for the  
17 purpose of this article; or

18 (B) substantially accepted  
19 peer-reviewed medical literature.

20 (b) Coverage of a drug required by this section  
21 shall include coverage of medically necessary services  
22 associated with the administration of the drug.

23 (c) A drug use that is covered under this  
24 section may not be denied based on a "medical  
25 necessity" requirement except for reasons that are  
26 unrelated to the legal status of the drug use.

27 (d) This section does not require coverage for:

28 (1) experimental drugs not otherwise  
29 approved for any indication by the Food and Drug  
30 Administration; or

31 (2) any disease or condition that is  
32 excluded from coverage under the plan.

33 (e) A health benefit plan is not required to  
34 cover a drug the Food and Drug Administration has  
35 determined to be contraindicated for treatment of the  
36 current indication.

37 Revised Law

38 Sec. 1369.005. RULES. The commissioner may adopt rules to  
39 implement this subchapter. (V.T.I.C. Art. 21.53M, Sec. 4.)

40 Source Law

41 Sec. 4. The commissioner may adopt rules to  
42 implement this article.

43 [Sections 1369.006-1369.050 reserved for expansion]

44 SUBCHAPTER B. COVERAGE OF PRESCRIPTION DRUGS

45 SPECIFIED BY DRUG FORMULARY

46 Revised Law

47 Sec. 1369.051. DEFINITIONS. In this subchapter:

48 (1) "Drug formulary" means a list of drugs:

49 (A) for which a health benefit plan provides

1 coverage;

2 (B) for which a health benefit plan issuer  
3 approves payment; or

4 (C) that a health benefit plan issuer encourages  
5 or offers incentives for physicians to prescribe.

6 (2) "Enrollee" means an individual who is covered  
7 under a group health benefit plan, including a covered dependent.

8 (3) "Physician" means a person licensed as a physician  
9 by the Texas State Board of Medical Examiners.

10 (4) "Prescription drug" has the meaning assigned by  
11 Section 551.003, Occupations Code. (V.T.I.C. Art. 21.52J, Secs.  
12 1(1), (2), (4), (5).)

13 Source Law

14 Art. 21.52J

15 Sec. 1. In this article:

16 (1) "Drug formulary" means a list of drugs  
17 for which a health benefit plan provides coverage,  
18 approves payment, or encourages or offers incentives  
19 for physicians to prescribe.

20 (2) "Enrollee" means an individual who is  
21 covered under a group health benefit plan, including a  
22 covered dependent.

23 (4) "Physician" means a person licensed as  
24 a physician by the Texas State Board of Medical  
25 Examiners.

26 (5) "Prescription drug" has the meaning  
27 assigned by Section 5, Texas Pharmacy Act (Article  
28 4542a-1, Vernon's Texas Civil Statutes).

29 Revisor's Note

30 (1) Section 1(3), V.T.I.C. Article 21.52J,  
31 defines "group health benefit plan." The revised law  
32 omits the definition as unnecessary because Section 2  
33 of that article, revised as Sections 1369.052 and  
34 1369.053, specifies the types of group health benefit  
35 plans to which this subchapter applies, and thus the  
36 defined term is not helpful to the reader. The omitted  
37 law reads:

38 (3) "Group health benefit plan"  
39 means a plan described by Section 2 of this  
40 article.

41 (2) Section 1(5), V.T.I.C. Article 21.52J,

1 refers to Section 5, Texas Pharmacy Act (Article  
2 4542a-1, Vernon's Texas Civil Statutes). That statute  
3 was codified in 1999 as Section 551.003, Occupations  
4 Code. The revised law is drafted accordingly.

5 Revised Law

6 Sec. 1369.052. APPLICABILITY OF SUBCHAPTER. This  
7 subchapter applies only to a group health benefit plan that  
8 provides benefits for medical or surgical expenses incurred as a  
9 result of a health condition, accident, or sickness, including a  
10 group, blanket, or franchise insurance policy or insurance  
11 agreement, a group hospital service contract, or a group contract  
12 or similar coverage document that is offered by:

- 13 (1) an insurance company;  
14 (2) a group hospital service corporation operating  
15 under Chapter 842;  
16 (3) a fraternal benefit society operating under  
17 Chapter 885;  
18 (4) a stipulated premium company operating under  
19 Chapter 884;  
20 (5) a reciprocal exchange operating under Chapter 942;  
21 (6) a health maintenance organization operating under  
22 Chapter 843;  
23 (7) a multiple employer welfare arrangement that holds  
24 a certificate of authority under Chapter 846; or  
25 (8) an approved nonprofit health corporation that  
26 holds a certificate of authority under Chapter 844. (V.T.I.C.  
27 Art. 21.52J, Sec. 2(a).)

28 Source Law

29 Sec. 2. (a) This article applies only to a  
30 group health benefit plan that provides benefits for  
31 medical or surgical expenses incurred as a result of a  
32 health condition, accident, or sickness, including a  
33 group, blanket, or franchise insurance policy or  
34 insurance agreement, a group hospital service  
35 contract, or a group contract or similar coverage  
36 document that is offered by:

- 37 (1) an insurance company;  
38 (2) a group hospital service corporation  
39 operating under Chapter 20 of this code;

1 (3) a fraternal benefit society operating  
2 under Chapter 10 of this code;

3 (4) a stipulated premium insurance company  
4 operating under Chapter 22 of this code;

5 (5) a reciprocal exchange operating under  
6 Chapter 19 of this code;

7 (6) a health maintenance organization  
8 operating under the Texas Health Maintenance  
9 Organization Act (Chapter 20A, Vernon's Texas  
10 Insurance Code);

11 (7) a multiple employer welfare  
12 arrangement that holds a certificate of authority  
13 under Article 3.95-2 of this code; or

14 (8) an approved nonprofit health  
15 corporation that holds a certificate of authority  
16 issued by the commissioner under Article 21.52F of  
17 this code.

18 Revisor's Note

19 Section 2(a)(8), V.T.I.C. Article 21.52J, refers  
20 to an approved nonprofit health corporation that holds  
21 a certificate of authority "issued by the  
22 commissioner." The revised law omits the quoted  
23 language for the reason stated in the revisor's note to  
24 Section 1369.002.

25 Revised Law

26 Sec. 1369.053. EXCEPTION. This subchapter does not apply  
27 to:

28 (1) a health benefit plan that provides coverage:

29 (A) only for a specified disease or for another  
30 single benefit;

31 (B) only for accidental death or dismemberment;

32 (C) for wages or payments in lieu of wages for a  
33 period during which an employee is absent from work because of  
34 sickness or injury;

35 (D) as a supplement to a liability insurance  
36 policy;

37 (E) for credit insurance;

38 (F) only for dental or vision care;

39 (G) only for hospital expenses; or

40 (H) only for indemnity for hospital confinement;

41 (2) a small employer health benefit plan written under  
42 Chapter 1501;

1 (3) a Medicare supplemental policy as defined by  
2 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),  
3 as amended;

4 (4) a workers' compensation insurance policy;

5 (5) medical payment insurance coverage provided under  
6 a motor vehicle insurance policy; or

7 (6) a long-term care insurance policy, including a  
8 nursing home fixed indemnity policy, unless the commissioner  
9 determines that the policy provides benefit coverage so  
10 comprehensive that the policy is a health benefit plan as described  
11 by Section 1369.052. (V.T.I.C. Art. 21.52J, Sec. 2(b).)

#### 12 Source Law

13 (b) This article does not apply to:

14 (1) a plan that provides coverage:

15 (A) only for a specified disease or  
16 other single benefit;

17 (B) only for accidental death or  
18 dismemberment;

19 (C) for wages or payments in lieu of  
20 wages for a period during which an employee is absent  
21 from work because of sickness or injury;

22 (D) as a supplement to liability  
23 insurance;

24 (E) for credit insurance;

25 (F) only for dental or vision care;

26 (G) only for hospital expenses; or

27 (H) only for indemnity for hospital  
28 confinement;

29 (2) a small employer health benefit plan  
30 written under Chapter 26 of this code;

31 (3) a Medicare supplemental policy as  
32 defined by Section 1882(g)(1), Social Security Act (42  
33 U.S.C. Section 1395ss), as amended;

34 (4) workers' compensation insurance  
35 coverage;

36 (5) medical payment insurance coverage  
37 issued as part of a motor vehicle insurance policy; or

38 (6) a long-term care policy, including a  
39 nursing home fixed indemnity policy, unless the  
40 commissioner determines that the policy provides  
41 benefit coverage so comprehensive that the policy is a  
42 health benefit plan as described by Subsection (a) of  
43 this section.

#### 44 Revised Law

45 Sec. 1369.054. NOTICE AND DISCLOSURE OF CERTAIN INFORMATION  
46 REQUIRED. An issuer of a group health benefit plan that covers  
47 prescription drugs and uses one or more drug formularies to specify  
48 the prescription drugs covered under the plan shall:

49 (1) provide in plain language in the coverage

1 documentation provided to each enrollee:

2 (A) notice that the plan uses one or more drug  
3 formularies;

4 (B) an explanation of what a drug formulary is;

5 (C) a statement regarding the method the issuer  
6 uses to determine the prescription drugs to be included in or  
7 excluded from a drug formulary;

8 (D) a statement of how often the issuer reviews  
9 the contents of each drug formulary; and

10 (E) notice that an enrollee may contact the  
11 issuer to determine whether a specific drug is included in a  
12 particular drug formulary;

13 (2) disclose to an individual on request, not later  
14 than the third business day after the date of the request, whether a  
15 specific drug is included in a particular drug formulary; and

16 (3) notify an enrollee and any other individual who  
17 requests information under this section that the inclusion of a  
18 drug in a drug formulary does not guarantee that an enrollee's  
19 health care provider will prescribe that drug for a particular  
20 medical condition or mental illness. (V.T.I.C. Art. 21.52J, Sec.  
21 3.)

#### 22 Source Law

23 Sec. 3. A group health benefit plan that covers  
24 prescription drugs and that uses one or more drug  
25 formularies to specify which prescription drugs the  
26 plan will cover shall:

27 (1) provide to each enrollee in plain  
28 language in the coverage documentation provided to the  
29 enrollee:

30 (A) notice that the plan uses one or  
31 more drug formularies;

32 (B) an explanation of what a drug  
33 formulary is;

34 (C) a statement regarding the method  
35 the plan uses to determine which prescription drugs  
36 are included in or excluded from a drug formulary;

37 (D) a statement of how often the plan  
38 reviews the contents of each drug formulary; and

39 (E) notice that the enrollee may  
40 contact the plan to find out if a specific drug is on a  
41 particular drug formulary;

42 (2) disclose to any individual on request,  
43 not later than the third business day after the date of  
44 the request, whether a specific drug is on a particular  
45 drug formulary; and

1 (3) notify an enrollee or any other  
2 individual who requests information about a drug  
3 formulary under this section that the presence of a  
4 drug on a drug formulary does not guarantee that an  
5 enrollee's health care provider will prescribe that  
6 drug for a particular medical condition or mental  
7 illness.

8 Revised Law

9 Sec. 1369.055. CONTINUATION OF COVERAGE REQUIRED; OTHER  
10 DRUGS NOT PRECLUDED. (a) An issuer of a group health benefit plan  
11 that covers prescription drugs shall offer to each enrollee at the  
12 contracted benefit level and until the enrollee's plan renewal date  
13 any prescription drug that was approved or covered under the plan  
14 for a medical condition or mental illness, regardless of whether  
15 the drug has been removed from the health benefit plan's drug  
16 formulary before the plan renewal date.

17 (b) This section does not prohibit a physician or other  
18 health professional who is authorized to prescribe a drug from  
19 prescribing a drug that is an alternative to a drug for which  
20 continuation of coverage is required under Subsection (a) if the  
21 alternative drug is:

22 (1) covered under the group health benefit plan; and

23 (2) medically appropriate for the enrollee. (V.T.I.C.  
24 Art. 21.52J, Sec. 4.)

25 Source Law

26 Sec. 4. (a) A group health benefit plan that  
27 offers prescription drug benefits shall make a  
28 prescription drug that was approved or covered for a  
29 medical condition or mental illness available to each  
30 enrollee at the contracted benefit level until the  
31 enrollee's plan renewal date, regardless of whether  
32 the prescribed drug has been removed from the health  
33 benefit plan's drug formulary.

34 (b) This section does not preclude a physician  
35 or other health professional authorized to prescribe a  
36 drug from prescribing another drug covered by the  
37 group health benefit plan that is medically  
38 appropriate for the enrollee.

39 Revised Law

40 Sec. 1369.056. ADVERSE DETERMINATION. (a) The refusal of  
41 a group health benefit plan issuer to provide benefits to an  
42 enrollee for a prescription drug is an adverse determination for  
43 purposes of Section 2, Article 21.58A, if:

1 (1) the drug is not included in a drug formulary used  
2 by the group health benefit plan; and

3 (2) the enrollee's physician has determined that the  
4 drug is medically necessary.

5 (b) The enrollee may appeal the adverse determination under  
6 Sections 6 and 6A, Article 21.58A. (V.T.I.C. Art. 21.52J, Sec. 5.)

7 Source Law

8 Sec. 5. If a group health benefit plan, through  
9 any of its employees or agents, refuses to provide  
10 benefits to an enrollee for a drug that is not included  
11 in a drug formulary and that the enrollee's physician  
12 has determined is medically necessary, the refusal  
13 constitutes an adverse determination for purposes of  
14 Section 2, Article 21.58A of this code. An enrollee  
15 may appeal the adverse determination under Sections 6  
16 and 6A, Article 21.58A of this code.

17 Revisor's Note

18 Section 5, V.T.I.C. Article 21.52J, refers to a  
19 refusal of a group health benefit plan "through any of  
20 its employees or agents." The revised law omits the  
21 reference to employees or agents as unnecessary  
22 because an action taken by a group health benefit plan  
23 is necessarily taken by an employee or agent of the  
24 plan.

25 Revised Law

26 Sec. 1369.057. RULES. The commissioner may adopt rules to  
27 implement this subchapter. (V.T.I.C. Art. 21.52J, Sec. 6.)

28 Source Law

29 Sec. 6. The commissioner may adopt rules to  
30 implement this article.

31 [Sections 1369.058-1369.100 reserved for expansion]

32 SUBCHAPTER C. COVERAGE OF PRESCRIPTION CONTRACEPTIVE

33 DRUGS AND DEVICES AND RELATED SERVICES

34 Revised Law

35 Sec. 1369.101. DEFINITIONS. In this subchapter:

36 (1) "Enrollee" means a person who is entitled to  
37 benefits under a health benefit plan.

38 (2) "Outpatient contraceptive service" means a

1 consultation, examination, procedure, or medical service that is  
2 provided on an outpatient basis and that is related to the use of a  
3 drug or device intended to prevent pregnancy. (V.T.I.C.  
4 Art. 21.52L, Sec. 1, as added Acts 77th Leg., R.S., Ch. 1106.)

5 Source Law

6 Art. 21.52L

7 Sec. 1. In this article:

8 (1) "Enrollee" means any person who is  
9 entitled to benefits under a health benefit plan.

10 (2) "Outpatient contraceptive service"  
11 means a consultation, examination, procedure, or  
12 medical service that is provided on an outpatient  
13 basis and that is related to the use of a drug or device  
14 intended to prevent pregnancy.

15 Revised Law

16 Sec. 1369.102. APPLICABILITY OF SUBCHAPTER. This  
17 subchapter applies only to a health benefit plan, including a small  
18 employer health benefit plan written under Chapter 1501, that  
19 provides benefits for medical or surgical expenses incurred as a  
20 result of a health condition, accident, or sickness, including an  
21 individual, group, blanket, or franchise insurance policy or  
22 insurance agreement, a group hospital service contract, or an  
23 individual or group evidence of coverage or similar coverage  
24 document that is offered by:

25 (1) an insurance company;

26 (2) a group hospital service corporation operating  
27 under Chapter 842;

28 (3) a fraternal benefit society operating under  
29 Chapter 885;

30 (4) a stipulated premium company operating under  
31 Chapter 884;

32 (5) a reciprocal exchange operating under Chapter 942;

33 (6) a health maintenance organization operating under  
34 Chapter 843;

35 (7) a multiple employer welfare arrangement that holds  
36 a certificate of authority under Chapter 846; or

37 (8) an approved nonprofit health corporation that  
38 holds a certificate of authority under Chapter 844. (V.T.I.C.

Art. 21.52L, Secs. 2(a), (b), as added Acts 77th Leg., R.S., Ch. 1106.)

Source Law

Sec. 2. (a) In this article, "health benefit plan" means a plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
  - (2) a group hospital service corporation operating under Chapter 20 of this code;
  - (3) a fraternal benefit society operating under Chapter 10 of this code;
  - (4) a stipulated premium insurance company operating under Chapter 22 of this code;
  - (5) a reciprocal exchange operating under Chapter 19 of this code;
  - (6) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);
  - (7) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or
  - (8) an approved nonprofit health corporation that holds a certificate of authority under Article 21.52F of this code.
- (b) "Health benefit plan" includes a small employer health benefit plan offered in accordance with Chapter 26 of this code.

Revised Law

Sec. 1369.103. EXCEPTION. This subchapter does not apply to:

- (1) a health benefit plan that provides coverage only:
  - (A) for a specified disease or for another limited benefit other than for cancer;
  - (B) for accidental death or dismemberment;
  - (C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
  - (D) as a supplement to a liability insurance policy;
  - (E) for credit insurance;
  - (F) for dental or vision care; or
  - (G) for indemnity for hospital confinement;

1           (2) a Medicare supplemental policy as defined by  
2 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),  
3 as amended;

4           (3) a workers' compensation insurance policy;

5           (4) medical payment insurance coverage provided under  
6 a motor vehicle insurance policy; or

7           (5) a long-term care insurance policy, including a  
8 nursing home fixed indemnity policy, unless the commissioner  
9 determines that the policy provides benefit coverage so  
10 comprehensive that the policy is a health benefit plan as described  
11 by Section 1369.102. (V.T.I.C. Art. 21.52L, Sec. 2(c), as added  
12 Acts 77th Leg., R.S., Ch. 1106.)

#### 13                           Source Law

14           (c) "Health benefit plan" does not include:

15               (1) a plan that provides coverage only:

16                       (A) for benefits for a specified  
17 disease or for another limited benefit other than for  
18 cancer;

19                       (B) for accidental death or  
20 dismemberment;

21                       (C) for wages or payments in lieu of  
22 wages for a period during which an employee is absent  
23 from work because of sickness or injury;

24                       (D) as a supplement to a liability  
25 insurance policy;

26                       (E) for credit insurance;

27                       (F) for dental or vision care; or

28                       (G) for indemnity for hospital  
29 confinement;

30               (2) a Medicare supplemental policy as  
31 defined by Section 1882(g)(1), Social Security Act (42  
32 U.S.C. Section 1395ss), as amended;

33               (3) a workers' compensation insurance  
34 policy;

35               (4) medical payment insurance coverage  
36 provided under a motor vehicle insurance policy; or

37               (5) a long-term care insurance policy,  
38 including a nursing home fixed indemnity policy,  
39 unless the commissioner determines that the policy  
40 provides benefit coverage so comprehensive that the  
41 policy is a health benefit plan as described by  
42 Subsection (a) of this section.

#### 43                           Revised Law

44           Sec. 1369.104. EXCLUSION OR LIMITATION PROHIBITED. (a) A  
45 health benefit plan that provides benefits for prescription drugs  
46 or devices may not exclude or limit benefits to enrollees for:

47               (1) a prescription contraceptive drug or device  
48 approved by the United States Food and Drug Administration; or

1 (2) an outpatient contraceptive service.

2 (b) This section does not prohibit a limitation that applies  
3 to all prescription drugs or devices or all services for which  
4 benefits are provided under a health benefit plan.

5 (c) This section does not require a health benefit plan to  
6 cover abortifacients or any other drug or device that terminates a  
7 pregnancy. (V.T.I.C. Art. 21.52L, Sec. 3, as added Acts 77th Leg.,  
8 R.S., Ch. 1106.)

9 Source Law

10 Sec. 3. (a) A health benefit plan that  
11 provides benefits for prescription drugs or devices  
12 may not exclude or limit benefits to enrollees for:

13 (1) a prescription contraceptive drug or  
14 device approved by the United States Food and Drug  
15 Administration; or

16 (2) an outpatient contraceptive service.

17 (b) This section does not prohibit a limitation  
18 that applies to all prescription drugs or devices or  
19 all services for which benefits are provided under a  
20 health benefit plan.

21 (c) This section does not provide coverage for  
22 abortifacients or any other drug or device that  
23 terminates a pregnancy.

24 Revised Law

25 Sec. 1369.105. CERTAIN COST-SHARING PROVISIONS PROHIBITED.

26 (a) A health benefit plan may not impose a deductible, copayment,  
27 coinsurance, or other cost-sharing provision applicable to  
28 benefits for prescription contraceptive drugs or devices unless the  
29 amount of the required cost-sharing is the same as or less than the  
30 amount of the required cost-sharing applicable to benefits for  
31 other prescription drugs or devices under the plan.

32 (b) A health benefit plan may not impose a deductible,  
33 copayment, coinsurance, or other cost-sharing provision applicable  
34 to benefits for outpatient contraceptive services unless the amount  
35 of the required cost-sharing is the same as or less than the amount  
36 of the required cost-sharing applicable to benefits for other  
37 outpatient services under the plan. (V.T.I.C. Art. 21.52L, Sec. 4,  
38 as added Acts 77th Leg., R.S., Ch. 1106.)

39 Source Law

40 Sec. 4. (a) A health benefit plan may not  
41 impose any deductible, copayment, coinsurance, or

1 other cost-sharing provision applicable to benefits  
2 for prescription contraceptive drugs or devices unless  
3 the amount of the required cost-sharing does not  
4 exceed the amount of the required cost-sharing  
5 applicable to benefits for other prescription drugs or  
6 devices under the plan.

7 (b) A health benefit plan may not impose any  
8 deductible, copayment, coinsurance, or other  
9 cost-sharing provision applicable to benefits for  
10 outpatient contraceptive services unless the amount of  
11 the required cost-sharing does not exceed the amount  
12 of the required cost-sharing applicable to benefits  
13 for other outpatient services under the plan.

14 Revised Law

15 Sec. 1369.106. CERTAIN WAITING PERIODS PROHIBITED. (a) A  
16 health benefit plan may not impose a waiting period applicable to  
17 benefits for prescription contraceptive drugs or devices unless the  
18 waiting period is the same as or shorter than any waiting period  
19 applicable to benefits for other prescription drugs or devices  
20 under the plan.

21 (b) A health benefit plan may not impose a waiting period  
22 applicable to benefits for outpatient contraceptive services  
23 unless the waiting period is the same as or shorter than any waiting  
24 period applicable to benefits for other outpatient services under  
25 the plan. (V.T.I.C. Art. 21.52L, Sec. 5, as added Acts 77th Leg.,  
26 R.S., Ch. 1106.)

27 Source Law

28 Sec. 5. (a) A health benefit plan may not  
29 impose any waiting period applicable to benefits for  
30 prescription contraceptive drugs or devices unless the  
31 waiting period is not longer than any waiting period  
32 applicable to benefits for other prescription drugs or  
33 devices under the plan.

34 (b) A health benefit plan may not impose any  
35 waiting period applicable to benefits for outpatient  
36 contraceptive services unless the waiting period is  
37 not longer than any waiting period applicable to  
38 benefits for other outpatient services under the plan.

39 Revised Law

40 Sec. 1369.107. PROHIBITED CONDUCT. A health benefit plan  
41 issuer may not:

42 (1) solely because of the applicant's or enrollee's  
43 use or potential use of a prescription contraceptive drug or device  
44 or an outpatient contraceptive service, deny:

45 (A) the eligibility of an applicant to enroll in

1 the plan;

2 (B) the continued eligibility of an enrollee for  
3 coverage under the plan; or

4 (C) the eligibility of an enrollee to renew  
5 coverage under the plan;

6 (2) provide a monetary incentive to an applicant for  
7 enrollment or an enrollee to induce the applicant or enrollee to  
8 accept coverage that does not satisfy the requirements of this  
9 subchapter; or

10 (3) reduce or limit a payment to a health care  
11 professional, or otherwise penalize the professional, because the  
12 professional prescribes a contraceptive drug or device or provides  
13 an outpatient contraceptive service. (V.T.I.C. Art. 21.52L, Sec.  
14 6, as added Acts 77th Leg., R.S., Ch. 1106.)

15 Source Law

16 Sec. 6. The issuer of a health benefit plan may  
17 not:

18 (1) deny an applicant for enrollment or an  
19 enrollee eligibility or continued eligibility under  
20 the plan, or deny renewal of a plan to an enrollee,  
21 solely because of the applicant's or enrollee's use or  
22 potential use of a prescription contraceptive drug or  
23 device or an outpatient contraceptive service;

24 (2) provide a monetary incentive to an  
25 applicant for enrollment or an enrollee to induce the  
26 applicant or enrollee to accept coverage that does not  
27 satisfy the requirements of this article; or

28 (3) reduce or limit a payment to a health  
29 care professional, or otherwise penalize the  
30 professional, because the professional prescribes a  
31 contraceptive drug or device or provides an  
32 outpatient contraceptive service.

33 Revised Law

34 Sec. 1369.108. EXEMPTION FOR ENTITIES ASSOCIATED WITH  
35 RELIGIOUS ORGANIZATION. (a) This subchapter does not require a  
36 health benefit plan that is issued by an entity associated with a  
37 religious organization or any physician or health care provider  
38 providing medical or health care services under the plan to offer,  
39 recommend, offer advice concerning, pay for, provide, assist in,  
40 perform, arrange, or participate in providing or performing a  
41 medical or health care service that violates the religious  
42 convictions of the organization, unless the prescription

1 contraceptive coverage is necessary to preserve the life or health  
2 of the enrollee.

3 (b) An issuer of a health benefit plan that excludes or  
4 limits coverage for medical or health care services under this  
5 section shall state the exclusion or limitation in:

6 (1) the plan's coverage document;

7 (2) the plan's statement of benefits;

8 (3) plan brochures; and

9 (4) other informational materials for the plan.

10 (V.T.I.C. Art. 21.52L, Sec. 7, as added Acts 77th Leg., R.S., Ch.  
11 1106.)

#### 12 Source Law

13 Sec. 7. (a) This article does not require a  
14 health benefit plan that is issued by an entity  
15 associated with a religious organization or any  
16 physician or health care provider providing medical or  
17 health care services under the health benefit plan to  
18 offer, recommend, offer advice concerning, pay for,  
19 provide, assist in, perform, arrange, or participate  
20 in providing or performing a medical or health care  
21 service that violates the religious convictions of the  
22 organization, except if the prescription  
23 contraceptive coverage is necessary to preserve the  
24 life or health of the insured individual.

25 (b) The issuer of a health benefit plan that  
26 limits or excludes coverage for medical or health care  
27 services under this section must state the limitation  
28 or exclusion in the coverage document, the plan's  
29 statement of benefits, brochures, and other  
30 informational materials for the health benefit plan.

#### 31 Revisor's Note

32 Section 7(a), V.T.I.C. Article 21.52L, as added  
33 by Chapter 1106, Acts of the 77th Legislature, Regular  
34 Session, 2001, refers to an "insured individual."  
35 "Insured" is a term used in conjunction with  
36 traditional insurance. This subchapter applies to  
37 health benefit plans offered by entities such as  
38 health maintenance organizations that are not  
39 insurers. Consequently, "enrollee" is a more accurate  
40 term than "insured individual." In addition,  
41 "enrollee" is the defined term used in the subchapter.  
42 Thus, the revised law substitutes "enrollee" for

"insured individual."

Revised Law

Sec. 1369.109. ENFORCEMENT. A health benefit plan issuer that violates this subchapter is subject to the enforcement provisions of Subtitle B, Title 2. (V.T.I.C. Art. 21.52L, Sec. 8, as added Acts 77th Leg., R.S., Ch. 1106.)

Source Law

Sec. 8. The issuer of a health benefit plan that violates this article is subject to the enforcement provisions of Subtitle B, Title 2, of this code.

[Sections 1369.110-1369.150 reserved for expansion]

SUBCHAPTER D. PHARMACY BENEFIT CARDS

Revised Law

Sec. 1369.151. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a reciprocal exchange operating under Chapter 942;
- (6) a health maintenance organization operating under Chapter 843;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C.

Art. 21.53L, Sec. 2(a).)

Source Law

Sec. 2. (a) This article applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 20 of this code;
- (3) a fraternal benefit society operating under Chapter 10 of this code;
- (4) a stipulated premium insurance company operating under Chapter 22 of this code;
- (5) a reciprocal exchange operating under Chapter 19 of this code;
- (6) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or
- (8) an approved nonprofit health corporation that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

Revisor's Note

Section 2(a)(8), V.T.I.C. Article 21.53L, refers to an approved nonprofit health corporation that holds a certificate of authority "issued by the commissioner." The revised law omits the quoted language for the reason stated in the revisor's note to Section 1369.002.

Revised Law

Sec. 1369.152. EXCEPTION. This subchapter does not apply to:

- (1) a health benefit plan that provides coverage:
  - (A) only for a specified disease or for another limited benefit;
  - (B) only for accidental death or dismemberment;
  - (C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.151. (V.T.I.C. Art. 21.53L, Sec. 2(b).)

#### Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) workers' compensation insurance coverage;

(5) medical payment insurance coverage issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a

1 health benefit plan as described by Subsection (a) of  
2 this section.

3 Revised Law

4 Sec. 1369.153. INFORMATION REQUIRED ON IDENTIFICATION  
5 CARD. (a) An issuer of a health benefit plan that provides  
6 pharmacy benefits to enrollees shall include on the identification  
7 card of each enrollee:

8 (1) the name or logo of the entity administering the  
9 pharmacy benefits if the entity is different from the health  
10 benefit plan issuer;

11 (2) the group number applicable to the enrollee;

12 (3) the effective date of the coverage evidenced by  
13 the card;

14 (4) a telephone number for contacting an appropriate  
15 person to obtain information relating to the pharmacy benefits  
16 provided under the plan; and

17 (5) copayment information for generic and brand-name  
18 prescription drugs.

19 (b) This section does not require a health benefit plan  
20 issuer that administers its own pharmacy benefits to issue an  
21 identification card separate from any identification card issued to  
22 an enrollee to evidence coverage under the plan if the  
23 identification card issued to evidence coverage contains the  
24 information required by Subsection (a). (V.T.I.C. Art. 21.53L,  
25 Sec. 3.)

26 Source Law

27 Sec. 3. (a) A health benefit plan that  
28 provides pharmacy benefits for enrollees in the plan  
29 shall include on the identification card of each  
30 enrollee:

31 (1) the name or logo of the entity that is  
32 administering the pharmacy benefits, if different from  
33 the health benefit plan;

34 (2) the group number applicable to the  
35 individual;

36 (3) the effective date of the coverage  
37 evidenced by the card;

38 (4) a telephone number to be used to  
39 contact an appropriate person to obtain information  
40 relating to the pharmacy benefits provided under the  
41 coverage; and

42 (5) copayment information for generic and  
43 brand-name prescription drugs.

(b) This section does not require a health benefit plan that administers its own pharmacy benefits to issue an identification card separate from any identification card issued to an enrollee to evidence coverage under the health benefit plan, if the identification card contains the elements required by Subsection (a) of this section.

Revised Law

Sec. 1369.154. RULES. The commissioner shall adopt rules as necessary to implement this subchapter. (V.T.I.C. Art. 21.53L, Sec. 4.)

Source Law

Sec. 4. The commissioner shall adopt rules as necessary to implement this article.

Revisor's Note  
(End of Subchapter)

Section 1, V.T.I.C. Article 21.53L, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1369.151 and 1369.152, specifies the types of health benefit plans to which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

Art. 21.53L  
Sec. 1. In this article, "health benefit plan" means a health benefit plan described by Section 2 of this article.

[Chapters 1370-1450 reserved for expansion]

SUBTITLE F. PHYSICIANS AND HEALTH CARE PROVIDERS

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21 CHAPTER 1451. ACCESS TO CERTAIN PRACTITIONERS AND FACILITIES

22 SUBCHAPTER A. GENERAL PROVISIONS

23 Revised Law

24 Sec. 1451.001. DEFINITIONS; HEALTH CARE PRACTITIONERS. In

25 this chapter:

26 (1) "Acupuncturist" means an individual licensed to

27 practice acupuncture by the Texas State Board of Medical Examiners.

28 (2) "Advanced practice nurse" means an individual

29 licensed by the Board of Nurse Examiners as a registered nurse and

30 recognized by that board as an advanced practice nurse.

31 (3) "Audiologist" means an individual licensed to

32 practice audiology by the State Board of Examiners for

33 Speech-Language Pathology and Audiology.

34 (4) "Chemical dependency counselor" means an

1 individual licensed by the Texas Commission on Alcohol and Drug  
2 Abuse.

3 (5) "Chiropractor" means an individual licensed by the  
4 Texas Board of Chiropractic Examiners.

5 (6) "Dentist" means an individual licensed to practice  
6 dentistry by the State Board of Dental Examiners.

7 (7) "Dietitian" means an individual licensed by the  
8 Texas State Board of Examiners of Dietitians.

9 (8) "Hearing instrument fitter and dispenser" means an  
10 individual licensed by the State Committee of Examiners in the  
11 Fitting and Dispensing of Hearing Instruments.

12 (9) "Licensed master social worker--advanced clinical  
13 practitioner" means an individual licensed by the Texas State Board  
14 of Social Worker Examiners as a licensed master social worker with  
15 the order of recognition of advanced clinical practitioner.

16 (10) "Licensed professional counselor" means an  
17 individual licensed by the Texas State Board of Examiners of  
18 Professional Counselors.

19 (11) "Marriage and family therapist" means an  
20 individual licensed by the Texas State Board of Examiners of  
21 Marriage and Family Therapists.

22 (12) "Occupational therapist" means an individual  
23 licensed as an occupational therapist by the Texas Board of  
24 Occupational Therapy Examiners.

25 (13) "Optometrist" means an individual licensed to  
26 practice optometry by the Texas Optometry Board.

27 (14) "Physical therapist" means an individual  
28 licensed as a physical therapist by the Texas Board of Physical  
29 Therapy Examiners.

30 (15) "Physician" means an individual licensed to  
31 practice medicine by the Texas State Board of Medical Examiners.  
32 The term includes a doctor of osteopathic medicine.

33 (16) "Physician assistant" means an individual  
34 licensed by the Texas State Board of Physician Assistant Examiners.

1           (17) "Podiatrist" means an individual licensed to  
2 practice podiatry by the Texas State Board of Podiatric Medical  
3 Examiners.

4           (18) "Psychological associate" means an individual  
5 licensed as a psychological associate by the Texas State Board of  
6 Examiners of Psychologists who practices solely under the  
7 supervision of a licensed psychologist.

8           (19) "Psychologist" means an individual licensed as a  
9 psychologist by the Texas State Board of Examiners of  
10 Psychologists.

11           (20) "Speech-language pathologist" means an  
12 individual licensed to practice speech-language pathology by the  
13 State Board of Examiners for Speech-Language Pathology and  
14 Audiology.

15           (21) "Surgical assistant" means an individual  
16 licensed as a surgical assistant by the Texas State Board of Medical  
17 Examiners. (V.T.I.C. Art. 3.70-2, Sec. (B) (part); Art. 21.52,  
18 Sec. 1 (part), as amended Acts 77th Leg., R.S., Ch. 1014.)

19                               Source Law

20           [Art. 3.70-2]

21           (B) . . .

22           For purposes of this Act, such designations shall  
23 have the following meanings:

24           Doctor of Medicine: One licensed by the Texas  
25 State Board of Medical Examiners on the basis of the  
26 degree "Doctor of Medicine";

27           Doctor of Osteopathy: One licensed by the Texas  
28 State Board of Medical Examiners on the basis of the  
29 degree of "Doctor of Osteopathy";

30           Doctor of Dentistry: One licensed by the State  
31 Board of Dental Examiners;

32           Doctor of Chiropractic: One licensed by the  
33 Texas Board of Chiropractic Examiners;

34           Doctor of Optometry: One licensed by the Texas  
35 Optometry Board;

36           Doctor of Podiatry: One licensed by the Texas  
37 State Board of Podiatric Medical Examiners;

38           Licensed Audiologist: One with a master's or  
39 doctorate degree in audiology from an accredited  
40 college or university and who is licensed as an  
41 audiologist by the State Board of Examiners for  
42 Speech-Language Pathology and Audiology;

43           Licensed Speech-language Pathologist: One with a  
44 master's or doctorate degree in speech pathology or  
45 speech-language pathology from an accredited college  
46 or university and who is licensed as a speech-language  
47 pathologist by the State Board of Examiners for  
48 Speech-Language Pathology and Audiology;

1 Doctor in Psychology: One licensed by the Texas  
2 State Board of Examiners of Psychologists and  
3 certified as a Health Service Provider;

4 Licensed Master Social Worker--Advanced Clinical  
5 Practitioner: One licensed by the Texas State Board of  
6 Social Worker Examiners as a Licensed Master Social  
7 Worker with the order of recognition of Advanced  
8 Clinical Practitioner;

9 Licensed Dietitian: One licensed by the Texas  
10 State Board of Examiners of Dietitians;

11 Licensed Professional Counselor: One licensed by  
12 the Texas State Board of Examiners of Professional  
13 Counselors;

14 Licensed Marriage and Family Therapist: One  
15 licensed by the Texas State Board of Examiners of  
16 Marriage and Family Therapists;

17 Licensed Chemical Dependency Counselor: One  
18 licensed by the Texas Commission on Alcohol and Drug  
19 Abuse;

20 Licensed Hearing Instrument Fitter and  
21 Dispenser: One licensed by the State Committee of  
22 Examiners in the Fitting and Dispensing of Hearing  
23 Instruments;

24 Advanced Practice Nurse: One licensed by the  
25 Board of Nurse Examiners as a registered nurse and  
26 recognized by that board as an advanced practice  
27 nurse;

28 Physician Assistant: One licensed by the Texas  
29 State Board of Physician Assistant Examiners;

30 Licensed Occupational Therapist: One licensed by  
31 the Texas Board of Occupational Therapy Examiners;

32 Licensed Physical Therapist: One licensed by the  
33 Texas Board of Physical Therapy Examiners;

34 Licensed Acupuncturist: One licensed by the  
35 Texas State Board of Medical Examiners as an  
36 acupuncturist;

37 Licensed Psychological Associate: One licensed  
38 by the Texas State Board of Examiners of Psychologists  
39 and practicing under the supervision of a licensed  
40 psychologist; and

41 Licensed Surgical Assistant: One licensed by the  
42 Texas State Board of Medical Examiners as a surgical  
43 assistant.

44 Art. 21.52

45 Sec. 1. As used in this article:

46 . . .  
47 (b) "doctor of podiatric medicine"  
48 includes D.P.M., podiatrist, doctor of surgical  
49 chiropody, D.S.C. and chiropodist;

50 (c) "doctor of optometry" includes  
51 optometrist, doctor of optometry, and O.D.;

52 (d) "doctor of chiropractic" means a  
53 person who is licensed by the Texas Board of  
54 Chiropractic Examiners to practice chiropractic;

55 (e) "licensed dentist" means a person who  
56 is licensed to practice dentistry by the State Board of  
57 Dental Examiners;

58 (f) "licensed audiologist" means a person  
59 who has received a master's or doctorate degree in  
60 audiology from an accredited college or university and  
61 is licensed as an audiologist by the State Board of  
62 Examiners for Speech-Language Pathology and  
63 Audiology;

64 (g) "licensed speech-language  
65 pathologist" means a person who has received a master's  
66 or doctorate degree in speech-language pathology from  
67 an accredited college or university and is licensed as

1 a speech-language pathologist by the State Board of  
2 Examiners for Speech-Language Pathology and  
3 Audiology;

4 (h) "licensed master social  
5 worker--advanced clinical practitioner" means a  
6 person who is licensed by the Texas State Board of  
7 Social Worker Examiners as a licensed master social  
8 worker with the order of recognition of advanced  
9 clinical practitioner;

10 (i) "licensed dietitian" means a person  
11 who is licensed by the Texas State Board of Examiners  
12 of Dietitians;

13 (j) "licensed professional counselor"  
14 means a person who is licensed by the Texas State Board  
15 of Examiners of Professional Counselors;

16 (k) "psychologist" means a person licensed  
17 to practice psychology by the Texas State Board of  
18 Examiners of Psychologists;

19 (l) "licensed marriage and family  
20 therapist" means a person who is licensed by the Texas  
21 State Board of Examiners of Marriage and Family  
22 Therapists;

23 (m) "licensed chemical dependency  
24 counselor" means a person who is licensed by the Texas  
25 Commission on Alcohol and Drug Abuse;

26 (n) "licensed hearing instrument fitter  
27 and dispenser" means a person who is licensed by the  
28 State Committee of Examiners in the Fitting and  
29 Dispensing of Hearing Instruments;

30 (o) "licensed psychological associate"  
31 means a person who is licensed by the Texas State Board  
32 of Examiners of Psychologists and who practices under  
33 the supervision of a licensed psychologist;

34 (p) "occupational therapist" means a  
35 person who is licensed to practice occupational  
36 therapy by the Texas Board of Occupational Therapy  
37 Examiners;

38 (q) "physical therapist" means a person  
39 who practices physical therapy and is licensed by the  
40 Texas Board of Physical Therapy Examiners;

41 (r) "advanced practice nurse" means a  
42 person licensed by the Board of Nurse Examiners and  
43 recognized by that board as an advanced practice  
44 nurse;

45 (s) "licensed acupuncturist" means a  
46 person licensed to practice acupuncture by the Texas  
47 State Board of Medical Examiners;

48 (t) "physician assistant" means a person  
49 licensed by the Texas State Board of Physician  
50 Assistant Examiners; and

51 (u) "Surgical assistant" means a person  
52 licensed by the Texas State Board of Medical Examiners  
53 as a surgical assistant.

54 Revisor's Note

55 (1) Section (B), V.T.I.C. Article 3.70-2, and  
56 Section 1, V.T.I.C. Article 21.52, each contain a list  
57 of regulated health care practitioners who may be  
58 designated under certain health benefit plans to  
59 provide services to covered individuals. In general,  
60 the lists are substantively very similar. Article

1 3.70-2, originally enacted in 1955, uses older  
2 terminology than the designations used in Article  
3 21.52, which was enacted in 1977. In addition, the  
4 list in Article 21.52 includes "nurse first assistant"  
5 which is not included in the list in Article 3.70-2.  
6 In 1999, the 76th Legislature originally enacted Title  
7 3 of the Occupations Code, which contains the  
8 licensing acts for each of the health care professions  
9 listed in Articles 3.70-2 and 21.52. To avoid  
10 redundancy and to conform to the latest statement of  
11 legislative intent regarding the regulated  
12 professions as evidenced by the Occupations Code, the  
13 revised law merges the two lists, other than "nurse  
14 first assistant," which is revised in Subchapter C  
15 with the remaining provisions of Article 21.52, and  
16 conforms the designations used throughout this chapter  
17 to the terms used for those professions in the  
18 Occupations Code.

19 (2) Section (B), V.T.I.C. Article 3.70-2,  
20 refers to a "doctor of medicine" and a "doctor of  
21 osteopathy." Under Subtitle B, Title 3, Occupations  
22 Code, both doctors of medicine and doctors of  
23 osteopathy are regulated by the Texas State Board of  
24 Medical Examiners and are issued licenses to practice  
25 medicine. Section 151.002, Occupations Code, defines  
26 "physician" as "a person licensed to practice medicine  
27 in this state." The revised law therefore substitutes  
28 "physician" for "doctor of medicine" and "doctor of  
29 osteopathy" throughout this chapter and adds an  
30 express reference in the definition to an osteopathic  
31 physician.

32 (3) Section (B), V.T.I.C. Article 3.70-2,  
33 refers to a "doctor of dentistry" as "[o]ne licensed by  
34 the State Board of Dental Examiners." Under Subtitle

1 D, Title 3, Occupations Code, the State Board of Dental  
2 Examiners licenses both dentists and dental  
3 hygienists. The revised law substitutes the term  
4 "dentist" for clarification.

5 (4) Section (B), V.T.I.C. Article 3.70-2, and  
6 Sections 1(f) and (g), V.T.I.C. Article 21.52, refer  
7 to a "licensed audiologist" and a "licensed  
8 speech-language pathologist" and specify certain  
9 educational requirements for those licenses. Under  
10 Chapter 401, Occupations Code, both audiologists and  
11 speech-language pathologists are regulated by the  
12 State Board of Examiners for Speech-Language Pathology  
13 and Audiology. Under Section 401.304, Occupations  
14 Code, to be eligible for a license as an audiologist or  
15 a speech-language pathologist, an applicant must  
16 comply with educational requirements that are  
17 substantially identical to those required under  
18 Articles 3.70-2 and 21.52. It is unnecessary to repeat  
19 those requirements in the revised law.

20 (5) Section (B), V.T.I.C. Article 3.70-2,  
21 refers to a "doctor in psychology" as a person licensed  
22 by the Texas State Board of Examiners of Psychologists  
23 "and certified as a Health Service Provider." The  
24 revised law omits the reference to certification as a  
25 health service provider because such a certification  
26 does not exist under Chapter 501, Occupations Code,  
27 the licensing statute for psychologists, or under the  
28 rules adopted to implement that chapter.

29 (6) Section (B), V.T.I.C. Article 3.70-2,  
30 refers to a "licensed physical therapist" as "[o]ne  
31 licensed by the Texas Board of Physical Therapy  
32 Examiners." Under Chapter 453, Occupations Code, that  
33 board licenses both physical therapists and physical  
34 therapist assistants. For clarification, the revised

1 law specifies that a physical therapist is a person  
2 licensed "as a physical therapist."

3 (7) Section (B), V.T.I.C. Article 3.70-2,  
4 refers to a "licensed occupational therapist" as  
5 "[o]ne licensed by the Texas Board of Occupational  
6 Therapy Examiners." Under Chapter 454, Occupations  
7 Code, that board licenses both occupational therapists  
8 and occupational therapy assistants. For  
9 clarification, the revised law specifies that an  
10 occupational therapist is a person licensed "as an  
11 occupational therapist."

12 [Sections 1451.002-1451.050 reserved for expansion]

13 SUBCHAPTER B. DESIGNATION OF PRACTITIONERS UNDER  
14 ACCIDENT AND HEALTH INSURANCE POLICY

15 Revised Law

16 Sec. 1451.051. APPLICABILITY OF SUBCHAPTER. (a) This  
17 subchapter applies to an accident and health insurance policy,  
18 including an individual, blanket, or group policy.

19 (b) This subchapter applies to an accident and health  
20 insurance policy issued by a stipulated premium company subject to  
21 Chapter 884. (V.T.I.C. Art. 3.70-8, Secs. (a) (part), (b).)

22 Source Law

23 Art. 3.70-8. (a) [Nothing in this Act shall  
24 apply to . . . any blanket or group policy of  
25 insurance except as provided in Subsections] (B)  
26 and . . . [of Section 2] . . . .

27 (b) This Act applies to a health, accident,  
28 sickness, and hospitalization policy issued by a  
29 stipulated premium insurer subject to Chapter 884 of  
30 this code.

31 Revisor's Note

32 Sections (a) and (b), V.T.I.C. Article 3.70-8,  
33 refer to a "blanket or group policy of insurance,"  
34 meaning a policy of accident and sickness insurance  
35 described by Section (B), V.T.I.C. Article 3.70-2, and  
36 to a "health, accident, sickness, and hospitalization  
37 policy," respectively. The revised law substitutes

1 the phrase "accident and health insurance" throughout  
2 this subchapter as appropriate for consistency with  
3 modern usage and the terminology used in Chapter 1201  
4 of this code.

5 Revised Law

6 Sec. 1451.052. APPLICABILITY OF GENERAL PROVISIONS OF OTHER  
7 LAW. The provisions of Chapter 1201, including provisions  
8 relating to the applicability, purpose, and enforcement of that  
9 chapter, the construction of policies under that chapter,  
10 rulemaking under that chapter, and definitions of terms applicable  
11 in that chapter, apply to this subchapter. (New.)

12 Revisor's Note

13 Chapter 397, Acts of the 54th Legislature,  
14 Regular Session, 1955, published as V.T.I.C. Articles  
15 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4,  
16 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and  
17 3.70-11, contains general provisions applicable to  
18 Section (B), V.T.I.C. Article 3.70-2, revised as this  
19 subchapter. The majority of those articles are  
20 revised in this code as Chapter 1201. Section 1451.052  
21 is added to indicate the applicability of those  
22 general provisions to this subchapter. For the  
23 convenience of the reader, the revised law includes  
24 general descriptions of some of the applicable  
25 provisions of Chapter 1201.

26 Revised Law

27 Sec. 1451.053. PRACTITIONER DESIGNATION. (a) An accident  
28 and health insurance policy may not make a benefit contingent on  
29 treatment or examination by one or more particular health care  
30 practitioners listed in Section 1451.001 unless the policy contains  
31 a provision that designates the practitioners whom the insurer will  
32 and will not recognize.

33 (b) The insurer may include the provision anywhere in the  
34 policy or in an endorsement attached to the policy. (V.T.I.C.

1 Art. 3.70-2, Sec. (B) (part).)

2 Source Law

3 (B) No policy of accident and sickness insurance  
4 shall make benefits contingent upon treatment or  
5 examination by a particular practitioner or by  
6 particular practitioners of the healing arts  
7 hereinafter designated unless such policy contains a  
8 provision designating the practitioner or  
9 practitioners who will be recognized by the insurer  
10 and those who will not be recognized by the insurer.  
11 Such provision may be located in the "Exceptions" or  
12 "Exceptions and Reductions" provisions, or elsewhere  
13 in the policy, or by endorsement attached to the  
14 policy, at the insurer's option. . . .

15 Revisor's Note

16 Section (B), V.T.I.C. Article 3.70-2, provides  
17 that "at the insurer's option" a provision that  
18 designates providers "may be located in the  
19 "Exceptions" or "Exceptions and Reductions"  
20 provisions, or elsewhere in the policy." The revised  
21 law omits as unnecessary the reference to the  
22 "Exceptions" or "Exceptions and Reductions"  
23 provisions. Because the insurer may locate the  
24 provision anywhere in the policy, a reference to an  
25 example of such a location is superfluous.

26 Revised Law

27 Sec. 1451.054. TERMS USED TO DESIGNATE HEALTH CARE  
28 PRACTITIONERS. A provision of an accident and health insurance  
29 policy that designates the health care practitioners whom the  
30 insurer will and will not recognize must use the terms defined by  
31 Section 1451.001 with the meanings assigned by that section.  
32 (V.T.I.C. Art. 3.70-2, Sec. (B) (part).)

33 Source Law

34 (B) . . . In designating the practitioners who  
35 will and will not be recognized, such provision shall  
36 use the following terms: Doctor of Medicine, Doctor of  
37 Osteopathy, Doctor of Dentistry, Doctor of  
38 Chiropractic, Doctor of Optometry, Doctor of Podiatry,  
39 Licensed Audiologist, Licensed Speech-language  
40 Pathologist, Doctor in Psychology, Licensed Master  
41 Social Worker--Advanced Clinical Practitioner,  
42 Licensed Dietitian, Licensed Professional Counselor,  
43 Licensed Marriage and Family Therapist, Licensed  
44 Chemical Dependency Counselor, Licensed Hearing  
45 Instrument Fitter and Dispenser, Advanced Practice

Nurse, Physician Assistant, Licensed Occupational  
Therapist, Licensed Physical Therapist, Licensed  
Acupuncturist, Licensed Psychological Associate, and  
Licensed Surgical Assistant.

. . .

[Sections 1451.055-1451.100 reserved for expansion]

#### SUBCHAPTER C. SELECTION OF PRACTITIONERS

##### Revised Law

Sec. 1451.101. DEFINITIONS. In this subchapter:

(1) "Health insurance policy" means a policy,  
contract, or agreement described by Section 1451.102.

(2) "Insured" means an individual who is issued, is a  
party to, or is a beneficiary under a health insurance policy.

(3) "Insurer" means an insurer, association, or  
organization described by Section 1451.102.

(4) "Nurse first assistant" has the meaning assigned  
by Section 301.1525, Occupations Code. (New; V.T.I.C. Art. 21.52,  
Sec. 1 (part), as amended Acts 77th Leg., R.S., Ch. 812.)

##### Source Law

Sec. 1. . . .

(u) "nurse first assistant" has the  
meaning assigned by Section 301.1525, Occupations  
Code.

##### Revisor's Note

The definitions of "health insurance policy,"  
"insured," and "insurer" are added to the revised law  
for drafting convenience and to avoid unnecessary  
repetition of the substance of the definitions.

##### Revised Law

Sec. 1451.102. APPLICABILITY OF SUBCHAPTER. Except as  
provided by this subchapter, this subchapter applies only to an  
individual, group, blanket, or franchise insurance policy,  
insurance agreement, or group hospital service contract that  
provides health benefits, accident benefits, or health and accident  
benefits for medical or surgical expenses incurred as a result of an  
accident or sickness and that is delivered, issued for delivery, or  
renewed in this state by any incorporated or unincorporated  
insurance company, association, or organization, including:

- 1           (1) a fraternal benefit society operating under  
2 Chapter 885;
- 3           (2) a general casualty company operating under Chapter  
4 861;
- 5           (3) a life, health, and accident insurance company  
6 operating under Chapter 841 or 982;
- 7           (4) a Lloyd's plan operating under Chapter 941;
- 8           (5) a local mutual aid association operating under  
9 Chapter 886;
- 10          (6) a mutual insurance company writing insurance other  
11 than life insurance operating under Chapter 883;
- 12          (7) a mutual life insurance company operating under  
13 Chapter 882;
- 14          (8) a reciprocal exchange operating under Chapter 942;
- 15          (9) a statewide mutual assessment company, mutual  
16 assessment company, or mutual assessment life, health, and accident  
17 association operating under Chapter 881 or 887; and
- 18          (10) a stipulated premium company operating under  
19 Chapter 884. (V.T.I.C. Art. 21.52, Secs. 1 (part), 2, 3(a) (part).)

20                           Source Law

21           Sec. 1. . . .

22           (a) "health insurance policy" means any  
23 individual, group, blanket, or franchise insurance  
24 policy, insurance agreement, or group hospital service  
25 contract, providing benefits for medical or surgical  
26 expenses incurred as a result of an accident or  
27 sickness;

28           . . . .

29           Sec. 2. This article applies to and embraces all  
30 insurance companies, associations, and organizations,  
31 whether incorporated or not, which provide health  
32 benefits, accident benefits, or health and accident  
33 benefits for medical or surgical expenses incurred as  
34 a result of an accident or sickness. Without limiting  
35 the foregoing, this article specifically applies to  
36 the insurance companies, associations, and  
37 organizations which come within the purview of the  
38 following designated chapters of the Insurance Code:  
39 Chapter 3, pertaining to life, health and accident  
40 insurance companies; Chapter 8, pertaining to general  
41 casualty companies; Chapter 10, pertaining to  
42 fraternal benefit societies; Chapter 11, pertaining to  
43 mutual life insurance companies; Chapter 12,  
44 pertaining to local mutual aid associations; Chapters  
45 13 and 14, pertaining to statewide mutual assessment  
46 companies, mutual assessment companies, and mutual  
47 assessment life, health and accident associations;

Chapter 15, pertaining to mutual insurance companies writing other than life insurance; Chapter 18, pertaining to underwriters making insurance on the Lloyd's plan; Chapter 19, pertaining to reciprocal exchanges; and Chapter 22, pertaining to stipulated premium insurance companies.

Sec. 3. (a) . . . any health insurance policy delivered, renewed, or issued for delivery in this state by any insurance company, association, or organization to which this article applies . . . .

#### Revisor's Note

(1) Section 2, V.T.I.C. Article 21.52, refers to Chapter 3 of the Insurance Code. The relevant portions of Chapter 3, relating to foreign and domestic entities that may be authorized to write the appropriate types of insurance, are revised in Chapters 841 and 982 of this code. The revised law is drafted accordingly.

(2) Section 2, V.T.I.C. Article 21.52, refers to Chapter 14 of the Insurance Code. The relevant portions of Chapter 14, relating to entities that may be authorized to write the appropriate types of insurance, are revised in Chapter 887 of this code. The revised law is drafted accordingly.

#### Revised Law

Sec. 1451.103. CONFLICTING PROVISIONS VOID. (a) A provision of a health insurance policy that conflicts with this subchapter is void to the extent of the conflict.

(b) The presence in a health insurance policy of a provision void under Subsection (a) does not affect the validity of other policy provisions.

(c) An insurer shall bring each approved policy form that contains a provision that conflicts with this subchapter into compliance with this subchapter by use of:

(1) a rider or endorsement approved by the commissioner; or

(2) a new or revised policy form approved by the commissioner. (V.T.I.C. Art. 21.52, Sec. 3(e).)

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1 services or procedures provided by another type of health care  
2 practitioner whose services or procedures are covered by a health  
3 insurance policy, in regard to:

4 (1) the payment schedule or payment provisions of the  
5 policy; or

6 (2) the amount or manner of payment or reimbursement  
7 under the policy.

8 (b) An insurer may not deny payment or reimbursement for  
9 services or procedures in accordance with the policy payment  
10 schedule or payment provisions solely because the services or  
11 procedures were performed by a health care practitioner selected  
12 under this subchapter.

13 (c) Notwithstanding Subsection (a), a health insurance  
14 policy may provide for a different amount of payment or  
15 reimbursement for scheduled services or procedures performed by an  
16 advanced practice nurse, nurse first assistant, licensed surgical  
17 assistant, or physician assistant if the methodology used to  
18 compute the amount is the same as the methodology used to compute  
19 the amount of payment or reimbursement when the services or  
20 procedures are provided by a physician. (V.T.I.C. Art. 21.52, Secs.  
21 3(c) (part), (d) (part), as amended Acts 77th Leg., R.S., Chs. 812,  
22 1014.)

23 Source Law

24 (c) The payment or reimbursement by the  
25 insurance company, association, or organization for  
26 services or procedures in accordance with the payment  
27 schedule or the payment provisions in the policy shall  
28 not be denied because the same were performed  
29 by . . . .

30 (d) There shall not be any classification,  
31 differentiation, or other discrimination in the  
32 payment schedule or the payment provisions in a health  
33 insurance policy, nor in the amount or manner of  
34 payment or reimbursement thereunder, between  
35 scheduled services or procedures when performed  
36 by . . . which fall within the scope of that  
37 practitioner's license or certification and the same  
38 services or procedures when performed by any other  
39 practitioner of the healing arts whose services or  
40 procedures are covered by the policy. However, a  
41 health insurance policy may provide for a different  
42 amount of payment or reimbursement for scheduled  
43 services or procedures when performed by an advanced  
44 practice nurse, a nurse first assistant, licensed

1 surgical assistant, or physician assistant provided  
2 the reimbursement methodology used to calculate the  
3 payment for the service or procedure is the same  
4 methodology used to calculate the payment when the  
5 service or procedure is provided by a physician.

6 Revisor's Note

7 (1) Sections 3(c) and (d), V.T.I.C. Article  
8 21.52, list specific health care practitioners and  
9 provide that an entity subject to the article may not  
10 deny payment or reimbursement for the services or  
11 procedures of those practitioners or discriminate  
12 between services or procedures provided by the  
13 specified practitioners and those provided by other  
14 health care practitioners. The revised law omits the  
15 lists of specific practitioners as unnecessary because  
16 they duplicate the list of practitioners who may be  
17 selected under this subchapter and defined by Section  
18 3(a) of the article, revised as Sections  
19 1451.105-1451.125. The omitted law reads:

20 (c) . . . a licensed doctor of  
21 podiatric medicine, a licensed doctor of  
22 optometry, a licensed doctor of  
23 chiropractic, a licensed dentist, an  
24 occupational therapist, a physical  
25 therapist, a licensed audiologist, a  
26 licensed speech-language pathologist, a  
27 licensed master social worker--advanced  
28 clinical practitioner, a licensed  
29 dietitian, a licensed professional  
30 counselor, a licensed marriage and family  
31 therapist, a psychologist, a licensed  
32 psychological associate, a licensed  
33 chemical dependency counselor, an advanced  
34 practice nurse, a nurse first assistant, a  
35 physician assistant, a licensed  
36 acupuncturist, or a licensed hearing  
37 instrument fitter and dispenser.

38 (d) . . . a doctor of podiatric  
39 medicine, a doctor of optometry, a doctor of  
40 chiropractic, a licensed dentist, an  
41 occupational therapist, a physical  
42 therapist, a licensed audiologist, a  
43 licensed speech-language pathologist, a  
44 licensed master social worker--advanced  
45 clinical practitioner, a licensed  
46 dietitian, a licensed professional  
47 counselor, a licensed marriage and family  
48 therapist, a psychologist, a licensed  
49 psychological associate, a licensed  
50 chemical dependency counselor, an advanced  
51 practice nurse to provide the services  
52 scheduled in the policy, a nurse first  
53 assistant to provide the services scheduled

1 in the policy and requested by the physician  
2 whom the nurse is assisting, a physician  
3 assistant to provide the services scheduled  
4 in the policy, a licensed acupuncturist, or  
5 a licensed hearing instrument fitter and  
6 dispenser . . . .

7 (2) Section 3(d), V.T.I.C. Article 21.52,  
8 refers to a practitioner's "license or certification."  
9 The revised law omits "certification" as unnecessary  
10 because each practitioner to which Article 21.52  
11 applies (see Section 1 of the article, revised as  
12 Section 1451.001) is required by law to obtain a  
13 license.

14 Revised Law

15 Sec. 1451.105. SELECTION OF ACUPUNCTURIST. An insured may  
16 select an acupuncturist to provide the services or procedures  
17 scheduled in the health insurance policy that are within the scope  
18 of the acupuncturist's license. (V.T.I.C. Art. 21.52, Sec. 3(a)  
19 (part).)

20 Source Law

21 Sec. 3. (a) Any person who is issued, who is a  
22 party to, or who is a beneficiary under [any health  
23 insurance policy delivered, renewed, or issued for  
24 delivery in this state by any insurance company,  
25 association, or organization to which this article  
26 applies] may select:

27 . . .  
28 (13) a licensed acupuncturist to perform  
29 the services or procedures scheduled in the policy  
30 that fall within the scope of the license of that  
31 practitioner;  
32 . . .

33 Revised Law

34 Sec. 1451.106. SELECTION OF ADVANCED PRACTICE NURSE. An  
35 insured may select an advanced practice nurse to provide the  
36 services scheduled in the health insurance policy that are within  
37 the scope of the nurse's license. (V.T.I.C. Art. 21.52, Sec. 3(a)  
38 (part).)

39 Source Law

40 Sec. 3. (a) Any person who is issued, who is a  
41 party to, or who is a beneficiary under [any health  
42 insurance policy delivered, renewed, or issued for  
43 delivery in this state by any insurance company,  
44 association, or organization to which this article  
45 applies] may select:

1 . . .  
2 (14) an advanced practice nurse to provide  
3 the services scheduled in the policy that fall within  
4 the scope of the license of that practitioner;  
5 . . .

6 Revised Law

7 Sec. 1451.107. SELECTION OF AUDIOLOGIST. An insured may  
8 select an audiologist to measure hearing to determine the presence  
9 or extent of the insured's hearing loss or provide aural  
10 rehabilitation services to the insured if the insured has a hearing  
11 loss and the services or procedures are scheduled in the health  
12 insurance policy. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

13 Source Law

14 Sec. 3. (a) Any person who is issued, who is a  
15 party to, or who is a beneficiary under [any health  
16 insurance policy delivered, renewed, or issued for  
17 delivery in this state by any insurance company,  
18 association, or organization to which this article  
19 applies] may select:

20 . . .  
21 (5) a licensed audiologist to measure  
22 hearing for the purpose of determining the presence or  
23 extent of a hearing loss and to provide aural  
24 rehabilitation services to a person with a hearing  
25 loss if those services or procedures are scheduled in  
26 the policy;  
27 . . .

28 Revised Law

29 Sec. 1451.108. SELECTION OF CHEMICAL DEPENDENCY  
30 COUNSELOR. An insured may select a chemical dependency counselor  
31 to provide services or procedures scheduled in the health insurance  
32 policy that are within the scope of the counselor's license.  
33 (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

34 Source Law

35 Sec. 3. (a) Any person who is issued, who is a  
36 party to, or who is a beneficiary under [any health  
37 insurance policy delivered, renewed, or issued for  
38 delivery in this state by any insurance company,  
39 association, or organization to which this article  
40 applies] may select:

41 . . .  
42 (12) a licensed chemical dependency  
43 counselor to perform the services or procedures  
44 scheduled in the policy that fall within the scope of  
45 the license of that practitioner;  
46 . . .

47 Revised Law

48 Sec. 1451.109. SELECTION OF CHIROPRACTOR. An insured may

1 select a chiropractor to provide the medical or surgical services  
2 or procedures scheduled in the health insurance policy that are  
3 within the scope of the chiropractor's license. (V.T.I.C.  
4 Art. 21.52, Sec. 3(a) (part).)

5 Source Law

6 Sec. 3. (a) Any person who is issued, who is a  
7 party to, or who is a beneficiary under [any health  
8 insurance policy delivered, renewed, or issued for  
9 delivery in this state by any insurance company,  
10 association, or organization to which this article  
11 applies] may select:

12 (1) . . . a doctor of chiropractic to  
13 perform the medical or surgical services or procedures  
14 scheduled in the policy which fall within the scope of  
15 the license of that practitioner;  
16 . . .

17 Revised Law

18 Sec. 1451.110. SELECTION OF DENTIST. An insured may select  
19 a dentist to provide the medical or surgical services or procedures  
20 scheduled in the health insurance policy that are within the scope  
21 of the dentist's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

22 Source Law

23 Sec. 3. (a) Any person who is issued, who is a  
24 party to, or who is a beneficiary under [any health  
25 insurance policy delivered, renewed, or issued for  
26 delivery in this state by any insurance company,  
27 association, or organization to which this article  
28 applies] may select:

29 (1) . . . a licensed dentist, or . . . to  
30 perform the medical or surgical services or procedures  
31 scheduled in the policy which fall within the scope of  
32 the license of that practitioner;  
33 . . .

34 Revised Law

35 Sec. 1451.111. SELECTION OF DIETITIAN. An insured may  
36 select a licensed dietitian or a provisionally licensed dietitian  
37 acting under the supervision of a licensed dietitian to provide the  
38 services scheduled in the health insurance policy that are within  
39 the scope of the dietitian's license. (V.T.I.C. Art. 21.52, Sec.  
40 3(a) (part).)

41 Source Law

42 Sec. 3. (a) Any person who is issued, who is a  
43 party to, or who is a beneficiary under [any health  
44 insurance policy delivered, renewed, or issued for  
45 delivery in this state by any insurance company,  
46 association, or organization to which this article

1 applies] may select:

2 . . .  
3 (8) a licensed dietitian including a  
4 provisional licensed dietitian under a licensed  
5 dietitian's supervision to provide the services that  
6 fall within the scope of the license of that dietitian  
7 if those services are scheduled in the policy;  
8 . . .

9 Revised Law

10 Sec. 1451.112. SELECTION OF HEARING INSTRUMENT FITTER AND  
11 DISPENSER. An insured may select a hearing instrument fitter and  
12 dispenser to provide the services or procedures scheduled in the  
13 health insurance policy that are within the scope of the license of  
14 the fitter and dispenser. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

15 Source Law

16 Sec. 3. (a) Any person who is issued, who is a  
17 party to, or who is a beneficiary under [any health  
18 insurance policy delivered, renewed, or issued for  
19 delivery in this state by any insurance company,  
20 association, or organization to which this article  
21 applies] may select:

22 . . .  
23 (16) a licensed hearing instrument fitter  
24 and dispenser to provide the services or procedures  
25 scheduled in the policy that fall within the scope of  
26 the license of that practitioner;  
27 . . .

28 Revised Law

29 Sec. 1451.113. SELECTION OF LICENSED MASTER SOCIAL  
30 WORKER--ADVANCED CLINICAL PRACTITIONER. (a) An insured may  
31 select a licensed master social worker--advanced clinical  
32 practitioner to provide the services or procedures scheduled in the  
33 health insurance policy that:

34 (1) are within the scope of the social worker's  
35 license, including the provision of direct, diagnostic,  
36 preventive, or clinical services to individuals, families, and  
37 groups whose functioning is threatened or affected by social or  
38 psychological stress or health impairment; and

39 (2) are specified as services under the terms of the  
40 health insurance policy.

41 (b) The health insurance policy may require that services of  
42 a licensed master social worker--advanced clinical practitioner  
43 must be recommended by a physician. (V.T.I.C. Art. 21.52, Secs.

1 3(a) (part), (b) (part).)

2 Source Law

3 Sec. 3. (a) Any person who is issued, who is a  
4 party to, or who is a beneficiary under [any health  
5 insurance policy delivered, renewed, or issued for  
6 delivery in this state by any insurance company,  
7 association, or organization to which this article  
8 applies] may select:

9 . . .  
10 (7) a licensed master social  
11 worker--advanced clinical practitioner to provide the  
12 services that fall within the scope of the license of  
13 such certified practitioner and which are specified as  
14 services within the terms of the policy of insurance,  
15 including the provision of direct, diagnostic,  
16 preventive, or clinical services to individuals,  
17 families, and groups whose functioning is threatened  
18 or affected by social or psychological stress or  
19 health impairment, if those services or procedures are  
20 scheduled in the policy;

21 . . .  
22 (b) The services of a licensed master social  
23 worker--advanced clinical practitioner, . . . that  
24 are included in this Act may require a professional  
25 recommendation by a doctor of medicine or doctor of  
26 osteopathy unless the health insurance policy terms do  
27 not require such a recommendation.

28 Revised Law

29 Sec. 1451.114. SELECTION OF LICENSED PROFESSIONAL  
30 COUNSELOR. (a) An insured may select a licensed professional  
31 counselor to provide the services scheduled in the health insurance  
32 policy that are within the scope of the counselor's license.

33 (b) The health insurance policy may require that services of  
34 a licensed professional counselor must be recommended by a  
35 physician. (V.T.I.C. Art. 21.52, Secs. 3(a) (part), (b) (part).)

36 Source Law

37 Sec. 3. (a) Any person who is issued, who is a  
38 party to, or who is a beneficiary under [any health  
39 insurance policy delivered, renewed, or issued for  
40 delivery in this state by any insurance company,  
41 association, or organization to which this article  
42 applies] may select:

43 . . .  
44 (9) a licensed professional counselor to  
45 provide the services that fall within the scope of the  
46 license of that professional if those services are  
47 scheduled in the policy;

48 . . .  
49 (b) The services of a . . . licensed  
50 professional counselor, or . . . that are included in  
51 this Act may require a professional recommendation by  
52 a doctor of medicine or doctor of osteopathy unless the  
53 health insurance policy terms do not require such a  
54 recommendation.

Revised Law

Sec. 1451.115. SELECTION OF SURGICAL ASSISTANT. An insured may select a surgical assistant to provide the services or procedures scheduled in the health insurance policy that are within the scope of the assistant's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part), as amended Acts 77th Leg., R.S., Ch. 1014.)

### Source Law

Sec. 3. (a) Any person who is issued, who is a party to, or who is a beneficiary under [any health insurance policy delivered, renewed, or issued for delivery in this state by any insurance company, association, or organization to which this article applies] may select:

(17) a licensed surgical assistant to provide the services or procedures scheduled in the policy that fall within the scope of the license of that practitioner; or

Revised Law

Sec. 1451.116. SELECTION OF MARRIAGE AND FAMILY THERAPIST. (a) An insured may select a marriage and family therapist to provide the services scheduled in the health insurance policy that are within the scope of the therapist's license.

(b) The health insurance policy may require that services of a marriage and family therapist must be recommended by a physician. (V.T.I.C. Art. 21.52, Secs. 3(a) (part), (b) (part).)

## Source Law

Sec. 3. (a) Any person who is issued, who is a party to, or who is a beneficiary under [any health insurance policy delivered, renewed, or issued for delivery in this state by any insurance company, association, or organization to which this article applies] may select:

(10) a licensed marriage and family therapist to provide the services that fall within the scope of the license of that professional if those services are scheduled in the policy;

(b) The services of a . . . licensed marriage and family therapist that are included in this Act may require a professional recommendation by a doctor of medicine or doctor of osteopathy unless the health insurance policy terms do not require such a recommendation.

## Revised Law

Sec. 1451.117. SELECTION OF NURSE FIRST ASSISTANT. An

1 insured may select a nurse first assistant to provide the services  
2 scheduled in the health insurance policy that:

3 (1) are within the scope of the nurse's license; and

4 (2) are requested by the physician whom the nurse is  
5 assisting. (V.T.I.C. Art. 21.52, Sec. 3(a) (part), as amended Acts  
6 77th Leg., R.S., Ch. 812.)

7 Source Law

8 Sec. 3. (a) Any person who is issued, who is a  
9 party to, or who is a beneficiary under [any health  
10 insurance policy delivered, renewed, or issued for  
11 delivery in this state by any insurance company,  
12 association, or organization to which this article  
13 applies] may select:

14 . . .  
15 (18) a nurse first assistant to provide  
16 the services scheduled in the policy that:

17 (A) fall within the scope of the  
18 license of that practitioner; and

19 (B) are requested by the physician  
20 whom the nurse is assisting.

21 Revised Law

22 Sec. 1451.118. SELECTION OF OCCUPATIONAL THERAPIST. An  
23 insured may select an occupational therapist to provide the  
24 services scheduled in the health insurance policy that are within  
25 the scope of the therapist's license. (V.T.I.C. Art. 21.52, Sec.  
26 3(a) (part).)

27 Source Law

28 Sec. 3. (a) Any person who is issued, who is a  
29 party to, or who is a beneficiary under [any health  
30 insurance policy delivered, renewed, or issued for  
31 delivery in this state by any insurance company,  
32 association, or organization to which this article  
33 applies] may select:

34 . . .  
35 (3) an occupational therapist to provide  
36 the services scheduled in the policy which fall within  
37 the scope of the license of that occupational  
38 therapist;

39 . . .

40 Revised Law

41 Sec. 1451.119. SELECTION OF OPTOMETRIST. An insured may  
42 select an optometrist to provide the services or procedures  
43 scheduled in the health insurance policy that are within the scope  
44 of the optometrist's license. (V.T.I.C. Art. 21.52, Sec. 3(a)  
45 (part).)

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(2) a licensed doctor of optometry to perform the services or procedures scheduled in the policy which fall within the scope of the license of that doctor of optometry;

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Sec. 1451.120. SELECTION OF PHYSICAL THERAPIST. An insured may select a physical therapist to provide the services scheduled in the health insurance policy that are within the scope of the therapist's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

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(4) a physical therapist to provide the services scheduled in the policy which fall within the scope of the license of that physical therapist;

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Sec. 1451.121. SELECTION OF PHYSICIAN ASSISTANT. An insured may select a physician assistant to provide the services scheduled in the health insurance policy that are within the scope of the assistant's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

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(15) a physician assistant to provide the services scheduled in the policy that fall within the scope of the license of that practitioner;

Revised Law

Sec. 1451.122. SELECTION OF PODIATRIST. An insured may select a podiatrist to provide the medical or surgical services or procedures scheduled in the health insurance policy that are within the scope of the podiatrist's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

### Source Law

Sec. 3. (a) Any person who is issued, who is a party to, or who is a beneficiary under [any health insurance policy delivered, renewed, or issued for delivery in this state by any insurance company, association, or organization to which this article applies] may select:

(1) a licensed doctor of podiatric medicine, . . . to perform the medical or surgical services or procedures scheduled in the policy which fall within the scope of the license of that practitioner;

. . .

Revised Law

Sec. 1451.123. SELECTION OF PSYCHOLOGICAL ASSOCIATE. An insured may select a psychological associate to provide the services scheduled in the health insurance policy that are within the scope of the associate's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part), as amended Acts 77th Leg., R.S., Ch. 1014.)

## Source Law

Sec. 3. (a) Any person who is issued, who is a party to, or who is a beneficiary under [any health insurance policy delivered, renewed, or issued for delivery in this state by any insurance company, association, or organization to which this article applies] may select:

(18) a licensed psychological associate to provide the services that fall within the scope of the license of that professional if those services are scheduled in the policy.

## Revised Law

Sec. 1451.124. SELECTION OF PSYCHOLOGIST. An insured may select a psychologist to provide the services or procedures scheduled in the health insurance policy that are within the scope of the psychologist's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

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(11) a psychologist to perform the services or procedures scheduled in the policy that fall within the scope of the license of that psychologist;

Sec. 1451.125. SELECTION OF SPEECH-LANGUAGE PATHOLOGIST.  
An insured may select a speech-language pathologist to evaluate  
speech or language, provide habilitative or rehabilitative  
services to restore speech or language loss, or correct a speech or  
language impairment if the services or procedures are scheduled in  
the health insurance policy. (V.T.I.C. Art. 21.52, Sec. 3(a)  
(part).)

Sec. 3. (a) Any person who is issued, who is a party to, or who is a beneficiary under [any health insurance policy delivered, renewed, or issued for delivery in this state by any insurance company, association, or organization to which this article applies] may select:

(6) a licensed speech-language pathologist to evaluate speech and language and to provide habilitative and rehabilitative services to restore speech or language loss or to correct a speech or language impairment if those services or procedures are scheduled in the policy;

Sec. 1451.126. REIMBURSEMENT FOR PHYSICAL MODALITIES AND PROCEDURES BY HEALTH INSURER, ADMINISTRATOR, HEALTH MAINTENANCE ORGANIZATION, OR PREFERRED PROVIDER BENEFIT PLAN ISSUER. (a) A health insurer or licensed third-party administrator may not deny reimbursement to a health care practitioner for the provision of covered services of physical modalities and procedures that are within the scope of the practitioner's practice if the services are performed in strict compliance with:

(1) laws and rules related to that practitioner's

1 license; and

2 (2) the terms of the insurance policy or other  
3 coverage agreement.

4 (b) A health maintenance organization or preferred provider  
5 benefit plan issuer may not deny reimbursement to a participating  
6 health care practitioner for services provided under a coverage  
7 agreement solely because of the type of practitioner providing the  
8 services if the services are performed in strict compliance with:

9 (1) laws and rules related to that practitioner's  
10 license; and

11 (2) the terms of the insurance policy or other  
12 coverage agreement.

13 (c) This section may not be construed to circumvent any  
14 contractual provider network agreement between a health insurer or  
15 third-party administrator and a licensed health care practitioner.  
16 (V.T.I.C. Art. 21.52, Sec. 3A.)

17 Source Law

18 Sec. 3A. (a) A health insurer or licensed third  
19 party administrator may not deny reimbursement to a  
20 practitioner for the provision of covered services of  
21 physical modalities and procedures that are within the  
22 scope of such practitioner's practice provided such  
23 services are performed in strict conformity with  
24 applicable laws and regulations relating to the  
25 licensure of the practitioner and with the terms of the  
26 insurance policy or other coverage agreement.

27 (b) A health maintenance organization or  
28 preferred provider organization may not deny  
29 reimbursement to a participating practitioner for  
30 services provided pursuant to a coverage agreement  
31 solely because of the type of practitioner who  
32 provided such services as long as the services are  
33 performed in strict conformity with applicable laws  
34 and regulations relating to the licensure of the  
35 practitioner and with the terms of the insurance  
36 policy or other coverage agreement.

37 (c) Nothing herein shall be construed to  
38 circumvent contractual provider network agreements  
39 between a health insurer or a third party  
40 administrator and licensed practitioners.

41 Revisor's Note

42 (1) Sections 3A(a) and (b), V.T.I.C. Article  
43 21.52, refer to "regulations." The revised law  
44 substitutes the term "rules" for "regulations" because  
45 in context the terms are synonymous, and because under

1       Section     311.005(5),     Government     Code     (Code  
2       Construction Act), a rule is defined to include a  
3       regulation. That definition applies to the revised  
4       law.

5               (2)   Section   3A(b),   V.T.I.C.   Article   21.52,  
6       provides that a "health maintenance organization or  
7       preferred provider organization" may not deny  
8       reimbursement in certain circumstances. The revised  
9       law substitutes "preferred provider benefit plan  
10      issuer" for "preferred provider organization" for  
11      clarity and consistency with terminology used in this  
12      code. In context, it is apparent that the provision is  
13      intended to apply to an entity that issues a preferred  
14      provider benefit plan.

15                               Revised Law

16       Sec. 1451.127.   DUTY OF PERSON ARRANGING PROVIDER CONTRACTS  
17   FOR HEALTH INSURER OR HEALTH MAINTENANCE ORGANIZATION. (a) A  
18   person who arranges contracts with providers on behalf of a health  
19   maintenance organization or health insurer shall comply with laws  
20   related to the duties of the organization or insurer to notify and  
21   consider providers for those contracts.

22       (b)   A violation of this section:

23               (1)   is an unlawful practice under Section 15.05,  
24   Business & Commerce Code; and

25               (2)   constitutes restraint of trade. (V.T.I.C.  
26   Art. 21.52, Sec. 4.)

27                               Source Law

28       Sec. 4. Each person who arranges contracts with  
29   providers on behalf of a health maintenance  
30   organization or health insurer shall comply with laws  
31   relating to the duties of the health maintenance  
32   organization or health insurer to notify and consider  
33   providers for those contracts. A violation of this  
34   section constitutes restraint of trade and is an  
35   unlawful practice under Section 15.05, Business &  
36   Commerce Code.

37       [Sections 1451.128-1451.150 reserved for expansion]

1 SUBCHAPTER D. ACCESS TO OPTOMETRISTS AND OPHTHALMOLOGISTS  
2 USED UNDER MANAGED CARE PLAN

3 Revised Law

4 Sec. 1451.151. DEFINITIONS. In this subchapter:

5 (1) "Managed care plan" means a plan under which a  
6 health maintenance organization, preferred provider benefit plan  
7 issuer, or other organization provides or arranges for health care  
8 benefits to plan participants and requires or encourages plan  
9 participants to use health care practitioners the plan designates.

10 (2) "Ophthalmologist" means a physician who  
11 specializes in ophthalmology. (V.T.I.C. Art. 21.52D, Sec. (a).)

12 Source Law

13 Art. 21.52D. (a) In this article:

14 (1) "Managed care plan" means a health  
15 maintenance organization, a preferred provider  
16 organization, or another organization that provides or  
17 arranges for health care benefits to participants and  
18 that requires or encourages participants to use health  
19 care practitioners designated by the plan.

20 (2) "Ophthalmologist" means a physician  
21 who is licensed by the Texas State Board of Medical  
22 Examiners and who specializes in ophthalmology.

23 Revisor's Note

24 Section (a)(1), V.T.I.C. Article 21.52D, refers  
25 to a "preferred provider organization." The revised  
26 law substitutes "preferred provider benefit plan  
27 issuer" for "preferred provider organization" for the  
28 reason stated in Revisor's Note (2) to Section  
29 1451.126.

30 Revised Law

31 Sec. 1451.152. APPLICABILITY AND CONSTRUCTION OF  
32 SUBCHAPTER. (a) This subchapter applies only to a managed care  
33 plan that provides or arranges for benefits for vision or medical  
34 eye care services or procedures that are within the scope of an  
35 optometrist's or therapeutic optometrist's license.

36 (b) This subchapter does not require a managed care plan to  
37 provide vision or medical eye care services or procedures.  
38 (V.T.I.C. Art. 21.52D, Secs. (b) (part), (c).)

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[illegible]

- (1) discriminate against a health care practitioner because the practitioner is an optometrist, therapeutic optometrist, or ophthalmologist;
- (2) fail to include optometrists, therapeutic optometrists, and ophthalmologists as participating practitioners in the plan;
- (3) restrict or discourage a participant from obtaining covered vision or medical eye care services or procedures from a participating optometrist, therapeutic optometrist, or ophthalmologist because the practitioner is an optometrist, therapeutic optometrist, or ophthalmologist;
- (4) fail to include the name of a participating optometrist, therapeutic optometrist, or ophthalmologist on a list of participating practitioners or fail to give equal prominence to the name;
- (5) fail to include an optometrist, therapeutic optometrist, or ophthalmologist as a participating practitioner in the plan because the optometrist, therapeutic optometrist, or ophthalmologist does not have medical staff privileges at a hospital or at a particular hospital; or
- (6) fail to include an optometrist, therapeutic optometrist, or ophthalmologist as a participating practitioner in the plan because the services or procedures provided by the optometrist, therapeutic optometrist, or ophthalmologist may be provided by another type of practitioner.

## SUBCHAPTER E. DENTAL CARE BENEFITS IN HEALTH INSURANCE

## Revised Law

(1) "Dental care service" means a service provided to a person to prevent, alleviate, cure, or heal a human dental illness or injury.

(2) "Employee benefit plan" means a plan, fund, or program established or maintained by an employer or employee organization.

(3) "Health insurance policy" means any individual, group, blanket, or franchise insurance policy, insurance agreement, or group hospital service contract. (V.T.I.C. Art. 21.53, Sec. 1 (part).)

## Source Law

Art. 21.53

Sec. 1. As used in this article:

(a) "health insurance policy" means any individual, group, blanket, or franchise insurance policy, insurance agreement, or group hospital service contract . . . ;

(b) "employee benefit plan" means any plan, fund, or program heretofore or hereafter established or maintained by an employer or by an employee organization, or by both, . . . ;

(c) "dental care services" means any services furnished to any person for the purpose of preventing, alleviating, curing, or healing human dental illness or injury;

• • •

## Revisor's Note

(1) Section 1(b), V.T.I.C. Article 21.53, refers to a plan, fund, or program established or maintained "heretofore or hereafter." The revised law omits the quoted language as unnecessary because it is not a limitation and encompasses any possible period. The revised law plainly applies to a plan, fund, or program irrespective of the time it was established or maintained.

(2) Section 1(d), V.T.I.C. Article 21.53, defines "dentist" as a person who "furnishes dental care services" and who is licensed as a dentist by this state. The revised law omits the definition as unnecessary because it substantively duplicates the definition provided by V.T.I.C. Articles 3.70-2 and 21.52, revised in pertinent part in Section 1451.001. The additional descriptive language in Section 1(d), V.T.I.C. Article 21.53, that refers to a dentist as a person who "furnishes dental care services" is unnecessary and does not add to the clear meaning of the law. The omitted law reads:

(d) "dentist" means any person who furnishes dental care services and who is licensed as a dentist by the State of Texas.

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(d) "dentist" means any person who furnishes dental care services and who is licensed as a dentist by the State of Texas.

## Revised Law

Sec. 1451.202. APPLICABILITY AND CONSTRUCTION OF

SUBCHAPTER. (a) This subchapter applies only to an employee benefit plan or health insurance policy delivered, issued for delivery, renewed, or contracted for in this state to the extent that:

(1) the employee benefit plan is established or maintained to provide dental care services, through insurance or otherwise, for the plan's participants or the beneficiaries of the plan's participants; or

(2) the health insurance policy provides benefits for dental care services.

(b) This subchapter does not apply to a health maintenance organization governed by Chapter 843.

(c) The exemptions and exceptions of Sections 881.002 and 881.004 and Article 21.41 do not apply to this subchapter.

(d) This subchapter does not require an employee benefit plan or health insurance policy to provide any type of benefits for dental care expenses. (V.T.I.C. Art. 21.53, Secs. 1(a) (part), (b) (part), 4 (part), 5, 6.)

Source Law

Sec. 1. . . .  
(a) . . . providing benefits for dental care services;  
(b) . . . to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, benefits for dental care services;  
. . .

Sec. 4. . . . which is delivered, renewed, issued for delivery, or otherwise contracted for in this state . . . .  
Sec. 5. The exemptions and exceptions in Articles 13.09 and 21.41 of the Insurance Code do not apply to this article. The provisions of this article do not apply to health maintenance organizations as defined and regulated by Chapter 20A of the Insurance Code.  
Sec. 6. The provisions of this article do not mandate that any type of benefits for dental care expenses be provided by a health insurance policy or an employee benefit plan.

Revised Law

Sec. 1451.203. CONFLICTING PROVISIONS. A provision of an employee benefit plan or health insurance policy that conflicts

1 with this subchapter is void to the extent of the conflict.  
2 (V.T.I.C. Art. 21.53, Sec. 4 (part).)

3 Source Law

4 Sec. 4. Any provision in a health insurance  
5 policy or employee benefit plan . . . which is  
6 contrary to this article shall to the extent of such  
7 conflict be void.

8 Revised Law

9 Sec. 1451.204. CERTAIN CONDUCT PERMITTED. (a)  
10 Notwithstanding any other provision of this subchapter, a dentist  
11 may contract directly with a patient to provide dental care  
12 services to the patient as authorized by law.

13 (b) Notwithstanding any other provision of this subchapter,  
14 a person providing a health insurance policy or employee benefit  
15 plan or an employer or an employee organization may:

16 (1) make information available to its insureds,  
17 beneficiaries, participants, employees, or members regarding  
18 dental care services through the distribution of factually accurate  
19 information about dental care services and the rates, fees,  
20 locations, and hours for the services if the information is  
21 distributed on the request of a dentist;

22 (2) establish an administrative mechanism to  
23 facilitate payments for dental care services from an insured,  
24 beneficiary, participant, employee, or member to a dentist chosen  
25 by the insured, beneficiary, participant, employee, or member; or

26 (3) nondiscriminatorily pay or reimburse its insured,  
27 beneficiary, participant, employee, or member for the cost of  
28 dental care services provided by a dentist chosen by the insured,  
29 beneficiary, participant, employee, or member. (V.T.I.C.  
30 Art. 21.53, Sec. 7.)

31 Source Law

32 Sec. 7. The provisions of this article do not  
33 prohibit the following conduct and shall be construed  
34 to provide that:

35 (a) a dentist may contract directly with a  
36 patient for the furnishing of dental care services to  
37 said patient as may be otherwise authorized by law;

38 (b) any person providing a health  
39 insurance policy or employee benefit plan, or an

1 employer, or an employee organization may:

2 (1) make available to its insureds,  
3 beneficiaries, participants, employees, or members  
4 information relating to dental care services by the  
5 distribution of factually accurate information  
6 regarding dental care services, rates, fees, location,  
7 and hours of service, provided such distribution is  
8 made upon the request of any dentist licensed by this  
9 state; or

10 (2) establish an administrative  
11 mechanism which facilitates payment for dental care  
12 services by insureds, beneficiaries, participants,  
13 employees, or members to the dentist of their choice;  
14 or

15 (3) pay or reimburse, on a  
16 nondiscriminatory basis, its insureds, beneficiaries,  
17 participants, employees, or members for the cost of  
18 dental care services rendered by the dentist of their  
19 choice.

20 Revised Law

21 Sec. 1451.205. DISCLOSURE OF BENEFIT TERMS. An employee  
22 benefit plan or health insurance policy shall:

23 (1) if applicable, disclose that the benefit for  
24 dental care services offered is limited to the least costly  
25 treatment; and

26 (2) specify in dollars and cents the amount of the  
27 payment or reimbursement to be provided for dental care services or  
28 define and explain the standard on which payment of benefits or  
29 reimbursement for the cost of dental care services is based, such  
30 as:

31 (A) "usual and customary" fees;

32 (B) "reasonable and customary" fees;

33 (C) "usual, customary, and reasonable" fees; or

34 (D) words of similar meaning. (V.T.I.C.

35 Art. 21.53, Sec. 3 (part).)

36 Source Law

37 Sec. 3. Any health insurance policy or employee  
38 benefit plan which is delivered, renewed, issued for  
39 delivery, or otherwise contracted for in this state  
40 shall, to the extent that it provides benefits for  
41 dental care services:

42 (a) disclose, if applicable, that the  
43 benefit offered is limited to the least costly  
44 treatment;

45 (b) define and explain the standard upon  
46 which the payment of benefits or reimbursement for the  
47 cost of dental care services is based, such as "usual  
48 and customary," "reasonable and customary," "usual,  
49 customary, and reasonable," fees or words of similar  
50 import or specify in dollars and cents the amount of

1 the payment or reimbursement for dental care services  
2 to be provided. . . .

3 Revised Law

4 Sec. 1451.206. PAYMENT OR REIMBURSEMENT OF DENTIST. (a)

5 The employee benefit plan or health insurance policy shall provide:

6 (1) that payment or reimbursement for a noncontracting  
7 provider dentist shall be the same as payment or reimbursement for a  
8 contracting provider dentist; and

9 (2) that the party to or beneficiary of the plan or  
10 policy may assign the right to payment or reimbursement to the  
11 dentist who provides the dental care services.

12 (b) Notwithstanding Subsection (a)(1), the employee benefit  
13 plan or health insurance policy is not required to make payment or  
14 reimbursement in an amount greater than:

15 (1) the amount specified in the plan or policy; or

16 (2) the fee the providing dentist charges for the  
17 dental care services provided.

18 (c) If the right to payment or reimbursement is assigned as  
19 provided by Subsection (a)(2):

20 (1) payment or reimbursement shall be made directly to  
21 the designated dentist; and

22 (2) direct payment to the designated dentist  
23 discharges the payor's obligation. (V.T.I.C. Art. 21.53, Sec. 3  
24 (part).)

25 Source Law

26 Sec. 3. Any health insurance policy or employee  
27 benefit plan . . . shall . . .

28 (b) . . . Said payment or reimbursement  
29 for a noncontracting provider dentist shall be the  
30 same as the payment or reimbursement for a contracting  
31 provider dentist; provided, however, that the health  
32 insurance policy or the employee benefit plan shall  
33 not be required to make payment or reimbursement in an  
34 amount which is greater than the amount so specified or  
35 which is greater than the fee charged by the providing  
36 dentist for the dental care services rendered; and

37 (c) provide that the party to or  
38 beneficiary of the health insurance policy or employee  
39 benefit plan may assign the right to benefits to the  
40 dentist who provides the dental care services, in  
41 which case, benefits shall be paid directly to the  
42 dentist designated. A payment made pursuant to this  
43 subsection discharges the payor's obligation to pay  
44 those benefits.

1 Revised Law

2 Sec. 1451.207. PROHIBITED CONDUCT. (a) An employee  
3 benefit plan or health insurance policy may not:

4 (1) interfere with or prevent an individual who is a  
5 party to or beneficiary of the plan or policy from selecting a  
6 dentist of the individual's choice to provide a dental care service  
7 the plan or policy offers if the dentist selected is licensed in  
8 this state to provide the service;

9 (2) deny a dentist the right to participate as a  
10 contracting provider under the plan or policy if the dentist is  
11 licensed to provide the dental care services the plan or policy  
12 offers;

13 (3) authorize a person to regulate, interfere with, or  
14 intervene in the provision of dental care services a dentist  
15 provides a patient, including diagnosis, if the dentist practices  
16 within the scope of the dentist's license; or

17 (4) require a dentist to make or obtain a dental x-ray  
18 or other diagnostic aid in providing dental care services.

19 (b) Subsection (a)(4) does not prohibit a request for an  
20 existing dental x-ray or other existing diagnostic aid for a  
21 determination of benefits payable under an employee benefit plan or  
22 health insurance policy.

23 (c) This section does not prohibit the predetermination of  
24 benefits for dental care expenses before the attending dentist  
25 provides treatment. (V.T.I.C. Art. 21.53, Sec. 2.)

26 Source Law

27 Sec. 2. No health insurance policy or employee  
28 benefit plan which is delivered, renewed, issued for  
29 delivery, or otherwise contracted for in this state  
30 shall:

31 (a) prevent any person who is a party to or  
32 beneficiary of any such health insurance policy or  
33 employee benefit plan from selecting the dentist of  
34 his choice to furnish the dental care services offered  
35 by said policy or plan or interfere with said selection  
36 provided the dentist is licensed to furnish such  
37 dental care services in this state;

38 (b) deny any dentist the right to  
39 participate as a contracting provider for such policy  
40 or plan provided the dentist is licensed to furnish the  
41 dental care services offered by said policy or plan;

1 (c) authorize any person to regulate,  
2 interfere, or intervene in any manner in the diagnosis  
3 or treatment rendered by a dentist to his patient for  
4 the purpose of preventing, alleviating, curing, or  
5 healing dental illness or injury provided said dentist  
6 practices within the scope of his license; or

7 (d) require that any dentist furnishing  
8 dental care services must make or obtain dental x-rays  
9 or any other diagnostic aids for the purpose of  
10 preventing, alleviating, curing, or healing dental  
11 illness or injury; provided, however, that nothing  
12 herein shall prohibit requests for existing dental  
13 x-rays or any other existing diagnostic aids for the  
14 purpose of determining benefits payable under a health  
15 insurance policy or employee benefit plan.

16 Nothing herein shall prohibit the  
17 predetermination of benefits for dental care expenses  
18 prior to treatment by the attending dentist.

19 [Sections 1451.208-1451.250 reserved for expansion]

20 SUBCHAPTER F. ACCESS TO OBSTETRICAL OR GYNECOLOGICAL CARE

21 Revised Law

22 Sec. 1451.251. DEFINITION. In this subchapter, "enrollee"  
23 means an individual enrolled in a health benefit plan. (V.T.I.C.  
24 Art. 21.53D, Sec. 1(1), as added Acts 75th Leg., R.S., Ch. 912.)

25 Source Law

26 Art. 21.53D

27 Sec. 1. In this article:

28 (1) "Enrollee" means an individual  
29 enrolled in a health benefit plan.

30 Revisor's Note

31 (1) Section 1(2), V.T.I.C. Article 21.53D, as  
32 added by Chapter 912, Acts of the 75th Legislature,  
33 Regular Session, 1997, defines "health benefit plan."  
34 The revised law omits the definition as unnecessary  
35 because Section 2 of that article, revised as Sections  
36 1451.252 and 1451.253, specifies the types of health  
37 benefit plans to which this subchapter applies, and  
38 thus the defined term is not helpful to the reader.  
39 The omitted law reads:

40 (2) "Health benefit plan" means  
41 a plan described in Section 2 of this  
42 article.

43 (2) Section 1(3), V.T.I.C. Article 21.53D, as  
44 added by Chapter 912, Acts of the 75th Legislature,  
45 Regular Session, 1997, defines "physician." The

revised law omits the definition as unnecessary because it duplicates the definition of the term as revised in Section 1451.001, which applies throughout this chapter. The omitted law reads:

(3) "Physician" means a person licensed as a physician by the Texas State Board of Medical Examiners.

Revised Law

Sec. 1451.252. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that requires an enrollee to obtain certain specialty health care services through a referral made by a primary care physician or other gatekeeper and that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

- (i) an insurance company;
- (ii) a group hospital service corporation operating under Chapter 842;
- (iii) a fraternal benefit society operating under Chapter 885;
- (iv) a stipulated premium company operating under Chapter 884; or
- (v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

- (i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or
- (ii) another analogous benefit

1 arrangement;

2 (2) is offered by:

3 (A) an approved nonprofit health corporation  
4 that holds a certificate of authority under Chapter 844; or

5 (B) an entity that is not authorized under this  
6 code or another insurance law of this state that contracts directly  
7 for health care services on a risk-sharing basis, including a  
8 capitation basis; or

9 (3) provides health and accident coverage through a  
10 risk pool created under Chapter 172, Local Government Code,  
11 notwithstanding Section 172.014, Local Government Code, or any  
12 other law. (V.T.I.C. Art. 21.53D, Secs. 2(a), (b), (d), as added  
13 Acts 75th Leg., R.S., Ch. 912.)

14 Source Law

15 Sec. 2. (a) This article applies to a health  
16 benefit plan that:

17 (1) provides benefits for medical or  
18 surgical expenses incurred as a result of a health  
19 condition, accident, or sickness, including:

20 (A) an individual, group, blanket, or  
21 franchise insurance policy or insurance agreement, a  
22 group hospital service contract, or an individual or  
23 group evidence of coverage that is offered by:

24 (i) an insurance company;  
25 (ii) a group hospital service  
26 corporation operating under Chapter 20 of this code;  
27 (iii) a fraternal benefit  
28 society operating under Chapter 10 of this code;  
29 (iv) a stipulated premium  
30 insurance company operating under Chapter 22 of this  
31 code; or

32 (v) a health maintenance  
33 organization operating under the Texas Health  
34 Maintenance Organization Act (Chapter 20A, Vernon's  
35 Texas Insurance Code); and

36 (B) to the extent permitted by the  
37 Employee Retirement Income Security Act of 1974 (29  
38 U.S.C. Section 1001 et seq.), a health benefit plan  
39 that is offered by:

40 (i) a multiple employer welfare  
41 arrangement as defined by Section 3, Employee  
42 Retirement Income Security Act of 1974 (29 U.S.C.  
43 Section 1002); or

44 (ii) another analogous benefit  
45 arrangement;

46 (2) is offered by an approved nonprofit  
47 health corporation that is certified under Section  
48 5.01(a), Medical Practice Act (Article 4495b, Vernon's  
49 Texas Civil Statutes), and that holds a certificate of  
50 authority issued by the commissioner under Article  
51 21.52F of this code; or

52 (3) is offered by any other entity not  
53 licensed under this code or another insurance law of

1 this state that contracts directly for health care  
2 services on a risk-sharing basis, including an entity  
3 that contracts for health care services on a  
4 capitation basis.

5 (b) Notwithstanding Section 172.014, Local  
6 Government Code, or any other law, this article  
7 applies to health and accident coverage provided by a  
8 risk pool created under Chapter 172, Local Government  
9 Code.

10 (d) This article applies to each health benefit  
11 plan that requires an enrollee to obtain certain  
12 specialty health care services through a referral made  
13 by a primary care physician or other gatekeeper.

14 Revisor's Note

15 (1) Section 2(a)(2), V.T.I.C. Article 21.53D,  
16 as added by Chapter 912, Acts of the 75th Legislature,  
17 Regular Session, 1997, refers to an approved nonprofit  
18 health corporation that is "certified under Section  
19 5.01(a), Medical Practice Act" and holds a certificate  
20 of authority "issued by the commissioner under Article  
21 21.52F." The revised law omits the reference to  
22 certification under Section 5.01(a), Medical Practice  
23 Act (Article 4495b, Vernon's Texas Civil Statutes),  
24 which was codified in 1999 in Chapter 162, Occupations  
25 Code, as unnecessary because V.T.I.C. Article 21.52F,  
26 revised as Chapter 844 of this code, requires a  
27 nonprofit corporation to be certified under that  
28 provision as a condition of holding a certificate of  
29 authority. The revised law also omits as unnecessary  
30 the reference to the commissioner issuing the  
31 certificate of authority because Chapter 844 requires  
32 the commissioner to issue the certificate of  
33 authority.

34 (2) Section 2(a)(3), V.T.I.C. Article 21.53D,  
35 as added by Chapter 912, Acts of the 75th Legislature,  
36 Regular Session, 1997, refers to a health benefit plan  
37 offered by an entity that is not "licensed" under the  
38 Insurance Code or another insurance law of this state.  
39 The revised law substitutes "authorized" for  
40 "licensed" for consistency with terminology used

1 throughout this code.

2 Revised Law

3 Sec. 1451.253. EXCEPTION. This subchapter does not apply  
4 to:

5 (1) a plan that provides coverage:

6 (A) only for a specified disease;

7 (B) only for accidental death or dismemberment;

8 (C) for wages or payments instead of wages for a  
9 period during which an employee is absent from work because of  
10 sickness or injury; or

11 (D) as a supplement to a liability insurance  
12 policy;

13 (2) a small employer health benefit plan written under  
14 Chapter 1501;

15 (3) a Medicare supplemental policy as defined by  
16 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

17 (4) a workers' compensation insurance policy;

18 (5) medical payment insurance coverage provided under  
19 a motor vehicle insurance policy;

20 (6) a long-term care insurance policy, including a  
21 nursing home fixed indemnity policy, unless the commissioner  
22 determines that the policy provides benefit coverage so  
23 comprehensive that the policy is a health benefit plan as described  
24 by Section 1451.252; or

25 (7) any health benefit plan that does not provide:

26 (A) benefits related to pregnancy; or

27 (B) well-woman care benefits. (V.T.I.C.  
28 Art. 21.53D, Sec. 2(c), as added Acts 75th Leg., R.S., Ch. 912.)

29 Source Law

30 (c) This article does not apply to:

31 (1) a plan that provides coverage:

32 (A) only for a specified disease;

33 (B) only for accidental death or  
34 dismemberment;

35 (C) for wages or payments in lieu of  
36 wages for a period during which an employee is absent  
37 from work because of sickness or injury; or

38 (D) as a supplement to liability

1 insurance;  
2 (2) a plan written under Chapter 26 of this  
3 code;  
4 (3) a Medicare supplemental policy as  
5 defined by Section 1882(g)(1), Social Security Act (42  
6 U.S.C. Section 1395ss);  
7 (4) workers' compensation insurance  
8 coverage;  
9 (5) medical payment insurance issued as a  
10 part of a motor vehicle insurance policy;  
11 (6) a long-term care policy, including a  
12 nursing home fixed indemnity policy, unless the  
13 commissioner determines that the policy provides  
14 benefit coverage so comprehensive that the policy is a  
15 health benefit plan as described by Subsection (a) of  
16 this section;  
17 (7) any health benefit plan that does not  
18 provide pregnancy-related benefits; or  
19 (8) any health benefit plan that does not  
20 provide well-woman care benefits.

#### 21 Revisor's Note

22 Section 2(c)(2), V.T.I.C. Article 21.53D, as  
23 added by Chapter 912, Acts of the 75th Legislature,  
24 Regular Session, 1997, refers to "a plan written under  
25 Chapter 26 of this code." The revised law refers to a  
26 "small employer health benefit plan written under  
27 Chapter 1501." When Article 21.53D was enacted,  
28 Chapter 26, codified as Chapter 1501 of this code,  
29 addressed only benefit plans offered by small  
30 employers. Provisions addressing benefit plans  
31 offered by large employers were later added to Chapter  
32 26 through the enactment of Chapter 955, Acts of the  
33 75th Legislature, Regular Session, 1997.  
34 Consequently, the reference to "a small employer  
35 health benefit plan" correctly reflects legislative  
36 intent.

#### 37 Revised Law

38 Sec. 1451.254. RULES. The commissioner shall adopt rules  
39 necessary to implement this subchapter. (V.T.I.C. Art. 21.53D,  
40 Sec. 6, as added Acts 75th Leg., R.S., Ch. 912.)

#### 41 Source Law

42 Sec. 6. The commissioner shall adopt rules as  
43 necessary to implement this article.

1 Revised Law

2 Sec. 1451.255. RIGHT OF FEMALE ENROLLEE TO SELECT  
3 OBSTETRICIAN OR GYNECOLOGIST. (a) Except as provided by  
4 Subsection (b), a health benefit plan shall permit a female  
5 enrollee to select, in addition to a primary care physician, an  
6 obstetrician or gynecologist to provide the enrollee with health  
7 care services that are within the scope of the professional  
8 specialty practice of a properly credentialed obstetrician or  
9 gynecologist.

10 (b) A health benefit plan may limit an enrollee's  
11 self-referral under Subsection (a) to only one participating  
12 obstetrician or gynecologist to provide both gynecological and  
13 obstetrical care to the enrollee. This subsection does not affect  
14 the right of an enrollee to select the physician who provides that  
15 care.

16 (c) This section does not preclude an enrollee from  
17 selecting a qualified physician, including a family physician or  
18 internal medicine physician, to provide the enrollee with health  
19 care services described by Subsection (a).

20 (d) This section does not affect the authority of a health  
21 benefit plan issuer to establish selection criteria regarding other  
22 physicians who provide services under the plan. (V.T.I.C.  
23 Art. 21.53D, Secs. 3(a), (c), 4(e), as added Acts 75th Leg., R.S.,  
24 Ch. 912.)

25 Source Law

26 Sec. 3. (a) Each health benefit plan subject  
27 to this article shall permit a woman who is entitled to  
28 coverage under the plan to select, in addition to a  
29 primary care physician, an obstetrician or  
30 gynecologist to provide health care services within  
31 the scope of the professional specialty practice of a  
32 properly credentialed obstetrician or gynecologist.  
33 This section does not preclude a woman from selecting a  
34 family physician, internal medicine physician, or  
35 other qualified physician to provide that care.

36 (c) This section does not affect the authority  
37 of a health benefit plan to establish selection  
38 criteria regarding other physicians who provide  
39 services through the plan.

40 [Sec. 4]

1           (e) In implementing the access required under  
2 Section 3 of this article, a health benefit plan may  
3 limit a woman enrolled in the plan to self-referral to  
4 one participating obstetrician and gynecologist for  
5 both gynecological care and obstetrical care. This  
6 subsection does not affect the right of the woman to  
7 select the physician who provides that care.

8                               Revised Law

9           Sec. 1451.256. DIRECT ACCESS TO SERVICES OF OBSTETRICIAN OR  
10 GYNECOLOGIST. (a) In this section, "health care services"  
11 includes:

12                       (1) one well-woman examination each year;  
13                       (2) care related to pregnancy;  
14                       (3) care for any active gynecological condition; and  
15                       (4) diagnosis, treatment, and referral for any disease  
16 or condition that is within the scope of the professional specialty  
17 practice of a properly credentialed obstetrician or gynecologist.

18           (b) In addition to other benefits authorized under the  
19 health benefit plan, a health benefit plan shall permit an enrollee  
20 who selects an obstetrician or gynecologist under Section 1451.255  
21 to have direct access to the health care services of that selected  
22 physician without:

23                       (1) a referral from the enrollee's primary care  
24 physician; or  
25                       (2) prior authorization or precertification from the  
26 plan issuer.

27           (c) A health benefit plan may not impose a copayment or  
28 deductible for direct access to health care services as required by  
29 this section unless the same copayment or deductible is imposed for  
30 access to other health care services provided under the plan.

31           (d) This section does not affect the authority of a health  
32 benefit plan issuer to require an obstetrician or gynecologist  
33 selected by an enrollee under Section 1451.255 to forward  
34 information concerning the medical care of the enrollee to the  
35 enrollee's primary care physician. (V.T.I.C. Art. 21.53D, Secs.  
36 4(a), (b), (c), (d) (part), as added Acts 75th Leg., R.S., Ch. 912.)

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(b)<sup>1</sup> The access to health care services required under this article includes, but is not limited to:

- (c) A health benefit plan may not impose a copayment or deductible for direct access to the health care services of an obstetrician or gynecologist under this section unless such an additional cost is imposed for access to other health care services provided under the plan.

Revisor's Note

Revised Law

1110

1 classification of persons authorized to provide medical services  
2 under the plan a sufficient number of properly credentialed  
3 obstetricians and gynecologists. (V.T.I.C. Art. 21.53D, Sec.  
4 3(b), as added Acts 75th Leg., R.S., Ch. 912.)

5 Source Law

6 (b) The plan shall include in the classification  
7 of persons authorized to provide medical services  
8 under the plan a number of properly credentialed  
9 obstetricians and gynecologists sufficient to ensure  
10 access to the services that fall within the scope of  
11 that credential.

12 Revised Law

13 Sec. 1451.258. NOTICE OF AVAILABLE PROVIDERS. (a) A  
14 health benefit plan issuer shall provide to each person covered  
15 under the plan a timely written notice of the choices of the types  
16 of physician providers available for the direct access required  
17 under this subchapter.

18 (b) The notice must be stated in clear and accurate  
19 language. (V.T.I.C. Art. 21.53D, Sec. 5, as added Acts 75th Leg.,  
20 R.S., Ch. 912.)

21 Source Law

22 Sec. 5. Each health benefit plan shall provide  
23 to persons covered by the plan a timely written notice  
24 in clear and accurate language of the choices of types  
25 of physician providers for the direct access to health  
26 care services required by this article.

27 Revised Law

28 Sec. 1451.259. LIMITS ON PHYSICIAN SANCTIONS. (a) A  
29 health benefit plan may not sanction or terminate a primary care  
30 physician because of female enrollees' access to participating  
31 obstetricians and gynecologists under this subchapter.

32 (b) A health benefit plan may not impose a financial or  
33 other penalty on an obstetrician or gynecologist selected under  
34 Section 1451.255, or on the enrollee who selected the physician,  
35 because the selected physician failed to provide to the enrollee's  
36 primary care physician information concerning the medical care of  
37 the enrollee if the selected physician made a reasonable good faith  
38 effort to forward the information. (V.T.I.C. Art. 21.53D, Secs.

1 4(d) (part), (f), as added Acts 75th Leg., R.S., Ch. 912.)

2 Source Law

3 (d) . . . [to require the designated  
4 obstetrician or gynecologist to forward information  
5 concerning the medical care of the patient to the  
6 primary care physician.] Failure to provide this  
7 information may not result in any penalty, financial  
8 or otherwise, being imposed upon the obstetrician or  
9 gynecologist or the patient by the health benefit plan  
10 if the obstetrician or gynecologist has made a  
11 reasonable and good-faith effort to provide the  
12 information to the primary care physician.

13 (f) A health benefit plan shall not sanction or  
14 terminate primary care physicians as a result of  
15 female enrollees' access to participating  
16 obstetricians and gynecologists under this section.

17 Revised Law

18 Sec. 1451.260. ADMINISTRATIVE PENALTY. An entity that  
19 operates a health benefit plan in violation of this subchapter is  
20 subject to an administrative penalty as provided by Chapter 84.  
21 (V.T.I.C. Art. 21.53D, Sec. 7, as added Acts 75th Leg., R.S., Ch.  
22 912.)

23 Source Law

24 Sec. 7. An insurance company, health maintenance  
25 organization, or other entity that operates a health  
26 benefit plan in violation of this article is subject to  
27 an administrative penalty as provided by Article 1.10E  
28 of this code.

29 Revisor's Note

30 Section 7, V.T.I.C. Article 21.53D, as added by  
31 Chapter 912, Acts of the 75th Legislature, Regular  
32 Session, 1997, refers to an "insurance company, health  
33 maintenance organization, or other entity that  
34 operates a health benefit plan." The revised law omits  
35 as unnecessary the references to "insurance company"  
36 and "health maintenance organization" because each is  
37 included within the meaning of "entity."

38 [Sections 1451.261-1451.300 reserved for expansion]

39 SUBCHAPTER G. ACCESS TO DIETITIAN SERVICES

40 Revised Law

41 Sec. 1451.301. APPLICABILITY OF GENERAL PROVISIONS OF OTHER  
42 LAW. The provisions of Chapter 1201, including provisions

1 relating to the applicability, purpose, and enforcement of that  
2 chapter, the construction of policies under that chapter,  
3 rulemaking under that chapter, and definitions of terms applicable  
4 in that chapter, apply to this subchapter. (New.)

5 Revisor's Note

6 Section (H), V.T.I.C. Article 3.70-2, was enacted  
7 as part of an amendment to Chapter 397, Acts of the  
8 54th Legislature, Regular Session, 1955, published as  
9 V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A,  
10 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8,  
11 3.70-9, 3.70-10, and 3.70-11. The majority of those  
12 articles, which include general provisions applicable  
13 to Section (H), V.T.I.C. Article 3.70-2, are revised  
14 in this code as Chapter 1201. Section 1451.301 is added  
15 to indicate the applicability of those general  
16 provisions to this subchapter. For the convenience of  
17 the reader, the revised law includes general  
18 descriptions of some of the applicable provisions of  
19 Chapter 1201.

20 Revised Law

21 Sec. 1451.302. DIETITIAN SERVICES. An individual or group  
22 accident and health insurance policy delivered or issued for  
23 delivery in this state may not:

24 (1) exclude or deny coverage for services performed  
25 by:

26 (A) a dietitian; or

27 (B) a provisionally licensed dietitian acting  
28 under the supervision of a dietitian; or

29 (2) refuse payment or reimbursement for charges for  
30 services described by Subdivision (1) if the services:

31 (A) are in the scope of the dietitian's license;

32 (B) are related to an injury or illness the  
33 policy covers if the services are scheduled in the policy; and

34 (C) are provided under a professional

1 recommendation of a physician whose treatment or examination for  
2 the injury or illness would be covered by the policy and would be  
3 payable or reimbursable under the policy. (V.T.I.C. Art. 3.70-2,  
4 Sec. (H), as amended Acts 70th Leg., R.S., Ch. 875, Sec. 2.)

5 Source Law

6 (H) An individual or group policy of accident or  
7 sickness insurance delivered or issued for delivery in  
8 this state may not exclude or deny coverage for  
9 services performed by a licensed dietitian, or by a  
10 provisional licensed dietitian under the supervision  
11 of a licensed dietitian, and may not refuse payment and  
12 reimbursement for charges for those services if the  
13 services are:

14 (1) within the scope of the licensed  
15 dietitian's license;

16 (2) related to an injury or illness  
17 covered by the policy if those services are scheduled  
18 in the policy; and

19 (3) provided under a professional  
20 recommendation by a doctor of medicine or doctor of  
21 osteopathy whose treatment or examination for the  
22 injury or illness would be covered by the policy and  
23 would be payable or reimbursable under the policy.

24 [Sections 1451.303-1451.350 reserved for expansion]

25 SUBCHAPTER H. DISABILITY CERTIFIED BY PODIATRIST

26 Revised Law

27 Sec. 1451.351. LOSS OF INCOME BENEFITS FOR DISABILITY  
28 TREATABLE BY PODIATRIST. (a) This section applies only to an  
29 insurance policy delivered, issued for delivery, or renewed in this  
30 state that provides benefits covering loss of income as a result of  
31 an acute temporary disability caused by sickness or injury.

32 (b) An insurance policy may not deny payment of benefits  
33 described by Subsection (a) solely because the disability is  
34 certified or attested to by a podiatrist if the disability is caused  
35 by a sickness or injury that may be treated within the scope of the  
36 podiatrist's license. (V.T.I.C. Art. 21.52A.)

37 Source Law

38 Art. 21.52A. An insurance policy that is  
39 delivered, issued for delivery, or renewed in this  
40 state and that provides benefits covering loss of  
41 income based on an acute and temporary disability  
42 caused by sickness or injury may not deny payment of  
43 those benefits on the ground that the acute and  
44 temporary disability is certified or attested to by a  
45 podiatrist licensed by the Texas State Board of  
46 Podiatric Medical Examiners if the acute and temporary  
47 disability is caused by a sickness or injury that may

1 be treated by acts performed by a licensed podiatrist  
2 under the scope of that license.

3 [Sections 1451.352-1451.400 reserved for expansion]

4 SUBCHAPTER I. USE OF OSTEOPATHIC HOSPITAL

5 Revised Law

6 Sec. 1451.401. CONTRACT WITH OSTEOPATHIC HOSPITAL. A  
7 health maintenance organization or preferred provider benefit plan  
8 issuer that contracts with a hospital to provide services to  
9 covered individuals may not refuse to contract with an osteopathic  
10 hospital solely because the hospital is an osteopathic hospital.  
11 (V.T.I.C. Art. 21.53B, Sec. (a).)

12 Source Law

13 Art. 21.53B. (a) A health maintenance or  
14 preferred provider organization that contracts with a  
15 hospital to provide services to covered individuals  
16 may not refuse to contract with a particular hospital  
17 solely because that hospital is an osteopathic  
18 hospital.

19 Revisor's Note

20 Section (a), V.T.I.C. Article 21.53B, refers to a  
21 "preferred provider organization." The revised law  
22 substitutes "preferred provider benefit plan issuer"  
23 for "preferred provider organization" for the reason  
24 stated in Revisor's Note (2) to Section 1451.126.

25 Revised Law

26 Sec. 1451.402. SERVICES AT OSTEOPATHIC HOSPITAL. A health  
27 maintenance organization or preferred provider benefit plan issuer  
28 that provides benefits for inpatient or outpatient services  
29 provided by an allopathic hospital shall seek to provide benefits  
30 for similar services provided by an osteopathic hospital if there  
31 is an osteopathic hospital within the service area of the health  
32 maintenance organization or preferred provider benefit plan issuer  
33 that will provide the services at a substantially similar cost.  
34 (V.T.I.C. Art. 21.53B, Sec. (b).)

35 Source Law

36 (b) A health maintenance or preferred provider  
37 organization that provides benefits for inpatient or  
38 outpatient services provided by allopathic hospitals  
39 shall seek to provide benefits for similar services

1 provided by an osteopathic hospital if there is an  
2 osteopathic hospital within the service area of the  
3 health maintenance or preferred provider organization  
4 that will provide those services at substantially  
5 similar cost.

6 Revisor's Note

7 Section (b), V.T.I.C. Article 21.53B, refers to a  
8 "preferred provider organization." The revised law  
9 substitutes "preferred provider benefit plan issuer"  
10 for "preferred provider organization" for the reason  
11 stated in Revisor's Note (2) to Section 1451.126.

12 Revised Law

13 Sec. 1451.403. REQUEST FOR ACTION OF COMMISSIONER. An  
14 aggrieved party may request that the commissioner conduct an  
15 investigation, review, hearing, or other proceeding to determine  
16 compliance with this subchapter. (V.T.I.C. Art. 21.53B, Sec. (c)  
17 (part).)

18 Source Law

19 (c) . . . An aggrieved party may ask the  
20 commissioner to conduct any investigation, review,  
21 hearing, or other proceeding to determine compliance  
22 with this section. . . .

23 Revised Law

24 Sec. 1451.404. ENFORCEMENT. The commissioner shall take  
25 all reasonable actions to ensure compliance with this subchapter,  
26 including issuing orders and assessing penalties. (V.T.I.C.  
27 Art. 21.53B, Sec. (c) (part).)

28 Source Law

29 (c) The commissioner shall have all necessary  
30 authority to enforce this section. . . . The  
31 commissioner shall take all reasonable steps,  
32 including the issuance of orders and the assessment of  
33 penalties, to ensure compliance with this section.

34 Revisor's Note

35 Section (c), V.T.I.C. Article 21.53B, provides  
36 that "[t]he commissioner shall have all necessary  
37 authority to enforce this section." The revised law  
38 omits the quoted language as unnecessary because it is  
39 redundant. An accepted principle of statutory  
40 construction provides that a statute that imposes a

duty on a public official confers on the official the authority to carry out the duty. Section (c), V.T.I.C. Article 21.53B, imposes a duty on the commissioner to "take all reasonable steps . . . to ensure compliance with this [article]," and so confers all necessary authority to enforce the article.

CHAPTER 1452. PHYSICIAN AND PROVIDER CREDENTIALS  
SUBCHAPTER A. CREDENTIALING OF PHYSICIANS AND PROVIDERS  
BY HEALTH MAINTENANCE ORGANIZATION

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[Sections 1452.007-1452.050 reserved for expansion]

SUBCHAPTER B. STANDARDIZED FORMS

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CHAPTER 1452. PHYSICIAN AND PROVIDER CREDENTIALS  
SUBCHAPTER A. CREDENTIALING OF PHYSICIANS AND PROVIDERS  
BY HEALTH MAINTENANCE ORGANIZATION

Revised Law

Sec. 1452.001. APPLICABILITY OF CERTAIN DEFINITIONS. In this subchapter, a term defined by Section 843.002 has the meaning assigned by that section. (V.T.I.C. Art. 20A.01B, as added Acts 77th Leg., R.S., Ch. 1419.)

Source Law

Art. 20A.01B. In this Act, terms defined by Section 843.002, Insurance Code, have the meanings assigned by that section.

1                                    Revised Law

2            Sec. 1452.002. VERIFICATION OF PHYSICIAN'S LICENSE OR  
3    CERTIFICATE. The commissioner shall require a health maintenance  
4    organization to verify that a physician's license to practice  
5    medicine and any other certificate the physician is required to  
6    hold, including a certificate issued by the Department of Public  
7    Safety or the federal Drug Enforcement Administration or a  
8    certificate issued under the Medicare program, is valid as of the  
9    date of:

- 10                    (1) initial credentialing of the physician; and  
11                    (2) each recredentialing.    (V.T.I.C. Art. 20A.39,  
12    Sec. (b).)

13                                    Source Law

14                    (b) The commissioner shall require a health  
15    maintenance organization to verify that a physician's  
16    license to practice medicine and any other certificate  
17    the physician is required to hold, including a  
18    certificate issued by the Department of Public Safety  
19    of the State of Texas or the federal Drug Enforcement  
20    Agency or a certificate issued under the Medicare  
21    program, is valid as of the date of initial  
22    credentialing and on the date of each recredentialing.

23                                    Revisor's Note

24                    Section (b), V.T.I.C. Article 20A.39, refers to  
25    the federal Drug Enforcement Agency. The correct name  
26    for that entity is the Drug Enforcement  
27    Administration. The revised law is drafted  
28    accordingly.

29                                    Revised Law

30            Sec. 1452.003. SITE VISIT FOR INITIAL CREDENTIALING. (a)  
31    The commissioner shall require a health maintenance organization  
32    that conducts a site visit for the purpose of initial credentialing  
33    of a physician or provider to evaluate during the visit a site's  
34    accessibility, appearance, space, medical or dental recordkeeping  
35    practices, availability of appointments, and confidentiality  
36    procedures.

37                    (b) The commissioner may not require the health maintenance  
38    organization to evaluate the appropriateness of equipment during

1 the site visit. (V.T.I.C. Art. 20A.39, Sec. (c).)

2 Source Law

3 (c) The commissioner shall require a health  
4 maintenance organization that conducts a site visit  
5 for the purpose of initial credentialing to evaluate  
6 during the visit a site's accessibility, appearance,  
7 space, medical or dental recordkeeping practices,  
8 availability of appointments, and confidentiality  
9 procedures. The commissioner may not require the  
10 health maintenance organization to evaluate the  
11 appropriateness of equipment during the site visit.

12 Revised Law

13 Sec. 1452.004. LIMITATION ON COMMISSIONER'S AUTHORITY. The  
14 commissioner may not require a health maintenance organization to:

15 (1) formally recredential a physician or provider more  
16 frequently than once in any three-year period;

17 (2) verify the validity of a license or certificate  
18 held by a physician as of a date other than the date of initial  
19 credentialing or recredentialing of the physician;

20 (3) use clinical personnel to perform a site visit for  
21 initial credentialing of a physician or provider unless clinical  
22 review is needed during the site visit; or

23 (4) require a site visit be performed for the purpose  
24 of recredentialing of a physician or provider. (V.T.I.C.  
25 Art. 20A.39, Sec. (d).)

26 Source Law

27 (d) The commissioner may not require that a  
28 health maintenance organization:

29 (1) formally recredential physicians or  
30 providers more frequently than once in any three-year  
31 period;

32 (2) verify the validity of a license or  
33 certificate held by a physician other than as of the  
34 date of initial credentialing or recredentialing of  
35 the physician;

36 (3) use clinical personnel to perform a  
37 site visit for initial credentialing of a physician or  
38 provider unless clinical review is needed during the  
39 site visit; or

40 (4) require a site visit be performed for  
41 recredentialing of a physician or provider.

42 Revised Law

43 Sec. 1452.005. SITE VISIT FOR CAUSE NOT PRECLUDED. This  
44 subchapter does not preclude a health maintenance organization from  
45 conducting a site visit of a physician or provider at any time for

1 cause, including a complaint made by a member or another external  
2 complaint made to the health maintenance organization. (V.T.I.C.  
3 Art. 20A.39, Sec. (e).)

4 Source Law

5 (e) This section does not preclude a health  
6 maintenance organization from performing a site visit  
7 of a physician or provider at any time for cause,  
8 including a complaint made by a member or another  
9 external complaint made to the health maintenance  
10 organization.

11 Revised Law

12 Sec. 1452.006. RULES RELATED TO SELECTION OF PHYSICIANS AND  
13 PROVIDERS BY HEALTH MAINTENANCE ORGANIZATION. A rule adopted by  
14 the commissioner under Section 843.102 that relates to  
15 implementation and maintenance by a health maintenance  
16 organization of a process for selecting and retaining affiliated  
17 physicians and providers must comply with:

18 (1) this subchapter; and

19 (2) standards adopted by the National Committee for  
20 Quality Assurance, to the extent those standards do not conflict  
21 with other laws of this state. (V.T.I.C. Art. 20A.39, Sec. (a).)

22 Source Law

23 Art. 20A.39. (a) Rules adopted by the  
24 commissioner under Section 37 of this Act that relate  
25 to implementation and maintenance by a health  
26 maintenance organization of a process for selecting  
27 and retaining affiliated physicians and providers must  
28 comply with:

29 (1) this section; and

30 (2) standards promulgated by the National  
31 Committee for Quality Assurance, to the extent those  
32 standards do not conflict with other laws of this  
33 state.

34 [Sections 1452.007-1452.050 reserved for expansion]

35 SUBCHAPTER B. STANDARDIZED FORMS

36 Revised Law

37 Sec. 1452.051. DEFINITION. In this subchapter,  
38 "physician" means an individual licensed to practice medicine in  
39 this state. (V.T.I.C. Art. 21.58D, Sec. 1.)

40 Source Law

41 Art. 21.58D

42 Sec. 1. In this article, "physician" means an

individual licensed to practice medicine in this state.

Revised Law

Sec. 1452.052. STANDARDIZED FORM FOR VERIFICATION OF PHYSICIAN CREDENTIALS. (a) The commissioner by rule shall:

(1) prescribe a standardized form for the verification of a physician's credentials; and

(2) require a public or private hospital, a health maintenance organization operating under Chapter 843, or the issuer of a preferred provider benefit plan under Chapter 1301 to use the form for verification of physician credentials.

(b) In prescribing a form under this section, the commissioner shall consider any credentialing application form that is widely used in this state. (V.T.I.C. Art. 21.58D, Sec. 2.)

Source Law

Sec. 2. (a) The commissioner by rule shall:  
(1) adopt a standardized form for the verification of the credentials of a physician; and  
(2) require that a public or private hospital, a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), or a preferred provider organization operating under Article 3.70-3C, Insurance Code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, use the form for verification of credentials.  
(b) In adopting a form under Subsection (a) of this section, the commissioner shall consider any credentialing application form that is widely used in this state.

Revisor's Note

Section 2(a)(2), V.T.I.C. Article 21.58D, refers to a "preferred provider organization operating under Article 3.70-3C, Insurance Code." The revised law substitutes "the issuer of a preferred provider benefit plan under Chapter 1301" for consistency with terminology used in V.T.I.C. Article 3.70-3C, revised as Chapter 1301 of this code.

CHAPTER 1453. DISCLOSURE OF REIMBURSEMENT GUIDELINES

UNDER MANAGED CARE PLAN

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3 CHAPTER 1453. DISCLOSURE OF REIMBURSEMENT GUIDELINES

4 UNDER MANAGED CARE PLAN

5 Revised Law

6 Sec. 1453.001. DEFINITIONS. In this chapter:

7 (1) "Health care provider" means:

8 (A) a hospital, emergency clinic, outpatient

9 clinic, or other facility providing health care services; or

10 (B) an individual who is licensed in this state

11 to provide health care services.

12 (2) "Managed care entity" means:

13 (A) a health maintenance organization;

14 (B) a preferred provider benefit plan issuer;

15 (C) an approved nonprofit health corporation

16 that holds a certificate of authority under Chapter 844; or

17 (D) another entity that offers a managed care

18 plan, including:

19 (i) an insurance company;

20 (ii) a group hospital service corporation

21 operating under Chapter 842;

22 (iii) a fraternal benefit society operating

23 under Chapter 885;

24 (iv) a stipulated premium company operating

25 under Chapter 884;

26 (v) a multiple employer welfare arrangement

27 that holds a certificate of authority under Chapter 846; and

28 (vi) an entity not authorized under this

29 code or another insurance law of this state that contracts directly

30 for health care services on a risk-sharing basis, including a

31 capitation basis.

32 (3) "Managed care plan" means a health benefit plan:

33 (A) under which health care services are provided

34 through contracts with health care providers to individuals

1 enrolled in or insured under the plan; and

2 (B) that provides financial incentives to  
3 individuals enrolled in or insured under the plan to use health care  
4 providers participating in the plan and procedures covered by the  
5 plan. (V.T.I.C. Art. 21.60, Sec. 1.)

6 Source Law

7 Art. 21.60

8 Sec. 1. In this article:

9 (1) "Health care provider" means:

10 (A) a hospital, emergency clinic,  
11 outpatient clinic, or other facility providing health  
12 care; or

13 (B) an individual who is licensed in  
14 this state to provide health care.

15 (2) "Managed care entity" means a health  
16 maintenance organization, a preferred provider  
17 organization, an approved nonprofit health  
18 corporation that holds a certificate of authority  
19 issued by the commissioner under Article 21.52F of  
20 this code, and any other entity that offers a managed  
21 care plan, including:

22 (A) an insurance company;

23 (B) a group hospital service  
24 corporation operating under Chapter 20 of this code;

25 (C) a fraternal benefit society  
26 operating under Chapter 10 of this code;

27 (D) a stipulated premium insurance  
28 company operating under Chapter 22 of this code;

29 (E) a multiple employer welfare  
30 arrangement that holds a certificate of authority  
31 under Article 3.95-2 of this code; or

32 (F) any entity not licensed under  
33 this code or another insurance law of this state that  
34 contracts directly for health care services on a  
35 risk-sharing basis, including an entity that contracts  
36 for health care services under a capitation method.

37 (3) "Managed care plan" means a health  
38 benefit plan:

39 (A) under which health care services  
40 are provided through contracts with health care  
41 professionals or health care facilities to persons  
42 enrolled in or insured under the plan; and

43 (B) that provides financial  
44 incentives to persons enrolled in or insured under the  
45 plan to use the participating practitioners,  
46 participating health care facilities, and procedures  
47 covered by the plan.

48 Revisor's Note

49 (1) Section 1(2), V.T.I.C. Article 21.60,  
50 states that a "managed care entity" means "a health  
51 maintenance organization, a preferred provider  
52 organization, an approved nonprofit health  
53 corporation . . . , and any other entity that offers a  
54 managed care plan." The revised law substitutes

1 "preferred provider benefit plan issuer" for  
2 "preferred provider organization" for clarity and  
3 consistency with terminology used in this code. In  
4 context, it is apparent that the provision is intended  
5 to apply to an entity that issues a preferred provider  
6 benefit plan.

7 (2) Section 1(2), V.T.I.C. Article 21.60,  
8 refers to an approved nonprofit health corporation  
9 that holds a certificate of authority "issued by the  
10 commissioner under Article 21.52F of this code." The  
11 revised law omits the reference to the commissioner  
12 issuing the certificate of authority as unnecessary  
13 because Article 21.52F, revised as Chapter 844 of this  
14 code, requires the commissioner to issue the  
15 certificate of authority.

16 (3) Section 1(2)(F), V.T.I.C. Article 21.60,  
17 refers to a managed care plan offered by an entity that  
18 is not "licensed" under the Insurance Code or another  
19 insurance law of this state. The revised law  
20 substitutes "authorized" for "licensed" for  
21 consistency with terminology used throughout this  
22 code.

23 (4) Section 1(3), V.T.I.C. Article 21.60,  
24 refers to "health care professionals or health care  
25 facilities" and "practitioners [and] health care  
26 facilities." The revised law substitutes "health care  
27 providers" for the quoted phrases because that is the  
28 defined term used in this chapter and, in context, the  
29 substance of the definition of that term is synonymous  
30 with the meaning of the quoted phrases.

31 Revised Law

32 Sec. 1453.002. PROVISION OF INFORMATION REGARDING  
33 REIMBURSEMENT GUIDELINES. (a) On the written request of an  
34 out-of-network health care provider, a managed care entity shall

1 furnish to the provider a written description of the factors  
2 considered by the entity in determining the amount of reimbursement  
3 the provider may receive for goods or services provided to an  
4 individual enrolled in or insured under the entity's managed care  
5 plan.

6 (b) This section does not require a managed care entity to  
7 disclose proprietary information that is prohibited from  
8 disclosure by a contract between the entity and a vendor that  
9 supplies payment or statistical data to the entity.

10 (c) A contract between a managed care entity and a vendor  
11 that supplies payment or statistical data to the entity may not  
12 prohibit the entity from disclosing under this section:

13 (1) the name of the vendor; or

14 (2) the methodology and origin of information used to  
15 determine the amount of reimbursement.

16 (d) A managed care entity that denies a request for  
17 information described by Subsection (b) shall send a copy of the  
18 request and the information requested to the department for review.

19 (V.T.I.C. Art. 21.60, Sec. 2.)

20 Source Law

21 Sec. 2. (a) On the written request of an  
22 out-of-network health care provider, a managed care  
23 entity shall provide the provider with a written  
24 description of the factors considered by the managed  
25 care entity in determining the amount of reimbursement  
26 that the out-of-network provider may receive for goods  
27 or services provided to a person enrolled in or insured  
28 under the entity's managed care plan.

29 (b) This article does not require a managed care  
30 entity to disclose proprietary information that a  
31 contract between the managed care entity and a vendor  
32 who supplies payment or statistical data to the  
33 managed care entity prohibits from disclosure.

34 (c) A contract between the managed care entity  
35 and a vendor who supplies payment or statistical data  
36 to the managed care entity may not prohibit the managed  
37 care entity from disclosing under this section:

38 (1) the name of the vendor; or

39 (2) the methodology and origin of  
40 information used to compute the amount of  
41 reimbursement.

42 (d) A managed care entity that denies a request  
43 for information under Subsection (b) of this section  
44 shall send a copy of the request and the information  
45 requested to the department for review.

Revised Law

Sec. 1453.003. RULES. The commissioner shall adopt rules as necessary to implement this chapter. (V.T.I.C. Art. 21.60, Sec. 3.)

### Source Law

Sec. 3. The commissioner shall adopt rules as necessary to implement this article.

## CHAPTER 1454. EQUAL HEALTH CARE FOR WOMEN

## SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1454.001. DEFINITIONS . . . . . 1127

Sec. 1454.002. APPLICABILITY OF CHAPTER . . . . . 1127

[Sections 1454.003-1454.050 reserved for expansion]

## SUBCHAPTER B. REIMBURSEMENT FOR HEALTH CARE SERVICES

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Sec. 1454.052. REIMBURSEMENT FOR ABORTION NOT REQUIRED . . . 1129

[Sections 1454.053-1454.100 reserved for expansion]

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AUTHORIZED . . . . . 1130

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1 CHAPTER 1454. EQUAL HEALTH CARE FOR WOMEN

2 SUBCHAPTER A. GENERAL PROVISIONS

3 Revised Law

4 Sec. 1454.001. DEFINITIONS. In this chapter:

5 (1) "Health care provider" means a home health aide,  
6 hospital, nurse practitioner, nurse midwife, outpatient care  
7 center, physician assistant, registered nurse, or surgery center.

8 (2) "Physician" has the meaning assigned by Section  
9 151.002, Occupations Code. (V.T.I.C. Art. 21.53N, Sec. 1.)

10 Source Law

11 Art. 21.53N

12 Sec. 1. In this article:

13 (1) "Physician" means a person licensed by  
14 the Texas State Board of Medical Examiners to practice  
15 medicine and surgery in this state.

16 (2) "Provider" means a hospital, nurse  
17 practitioner, registered nurse, physician assistant,  
18 home health aide, nurse midwife, surgery center, or  
19 other outpatient care center.

20 Revisor's Note

21 Section 1, V.T.I.C. Article 21.53N, defines  
22 "provider" by listing various health care providers.  
23 For consistency with this code and other codes and  
24 because "health care provider" more accurately  
25 describes the persons listed in the definition of  
26 "provider," the revised law substitutes "health care  
27 provider" for "provider." In addition, Section 1,  
28 V.T.I.C. Article 21.53N, defines "physician" in a  
29 manner that is substantively identical to Section  
30 151.002, Occupations Code. For consistency, the  
31 revised law therefore substitutes a cross-reference to  
32 that section of the Occupations Code for the  
33 definition provided by V.T.I.C. Article 21.53N.

34 Revised Law

35 Sec. 1454.002. APPLICABILITY OF CHAPTER. This chapter  
36 applies only to a health benefit plan that provides benefits for  
37 medical or surgical expenses incurred as a result of a health  
38 condition, accident, or sickness, including an individual, group,

1 blanket, or franchise insurance policy or insurance agreement, a  
2 group hospital service contract, or an individual or group evidence  
3 of coverage or similar coverage document that is offered by:

4 (1) an insurance company;

5 (2) a group hospital service corporation operating  
6 under Chapter 842;

7 (3) a fraternal benefit society operating under  
8 Chapter 885;

9 (4) a stipulated premium company operating under  
10 Chapter 884;

11 (5) a reciprocal exchange operating under Chapter 942;

12 (6) a health maintenance organization operating under  
13 Chapter 843;

14 (7) a multiple employer welfare arrangement that holds  
15 a certificate of authority under Chapter 846;

16 (8) an approved nonprofit health corporation that  
17 holds a certificate of authority under Chapter 844; or

18 (9) a small employer health benefit plan written under  
19 Chapter 1501. (V.T.I.C. Art. 21.53N, Sec. 2.)

20 Source Law

21 Sec. 2. This article applies only to a health  
22 benefit plan that provides benefits for medical or  
23 surgical expenses incurred as a result of a health  
24 condition, accident, or sickness, including an  
25 individual, group blanket, or franchise insurance  
26 policy or insurance agreement, a group hospital  
27 service contract, or an individual or group evidence  
28 of coverage or similar coverage document that is  
29 offered by:

30 (1) an insurance company;

31 (2) a group hospital service corporation  
32 operating under Chapter 20 of this code;

33 (3) a fraternal benefit society operating  
34 under Chapter 10 of this code;

35 (4) a stipulated premium insurance company  
36 operating under Chapter 22 of this code;

37 (5) a reciprocal exchange operating under  
38 Chapter 19 of this code;

39 (6) a health maintenance organization  
40 operating under the Texas Health Maintenance  
41 Organization Act (Chapter 20A, Vernon's Texas  
42 Insurance Code);

43 (7) a multiple employer welfare  
44 arrangement that holds a certificate of authority  
45 under Article 3.95-2 of this code;

46 (8) an approved nonprofit health  
47 corporation that holds a certificate of authority

1 under Article 21.52F of this code; or  
2 (9) a small employer health benefit plan  
3 written under Chapter 26 of this code.

4 [Sections 1454.003-1454.050 reserved for expansion]

5 SUBCHAPTER B. REIMBURSEMENT FOR HEALTH CARE SERVICES

6 Revised Law

7 Sec. 1454.051. EQUAL REIMBURSEMENT REQUIRED. A health  
8 benefit plan issuer that reimburses a physician or health care  
9 provider for reproductive health or oncology services provided to  
10 women must reimburse the physician or provider in an amount at least  
11 equal to the annual average compensation per hour or unit that would  
12 be paid in the service area to a physician or provider for the same  
13 medical, surgical, hospital, pharmaceutical, nursing, or other  
14 similar resources used to provide the services if the resources  
15 would be used to provide health services exclusively to men or to  
16 the general population. (V.T.I.C. Art. 21.53N, Sec. 3.)

17 Source Law

18 Sec. 3. When reimbursing a physician or provider  
19 for reproductive health and oncology services provided  
20 to women, a health benefit plan must pay an amount not  
21 less than the annual average compensation per hour or  
22 unit as would be paid in the service area to a  
23 physician or provider for the same medical, surgical,  
24 hospital, pharmaceutical, nursing, or other similar  
25 resources, as applicable, that would be used in  
26 providing health services exclusively to men or to the  
27 general population.

28 Revised Law

29 Sec. 1454.052. REIMBURSEMENT FOR ABORTION NOT REQUIRED.  
30 This chapter does not require a health benefit plan issuer to  
31 provide reimbursement for an abortion, as defined by the Family  
32 Code, or for a service related to an abortion. (V.T.I.C.  
33 Art. 21.53N, Sec. 6.)

34 Source Law

35 Sec. 6. This article does not require the issuer  
36 of a health benefit plan to provide reimbursement for  
37 an abortion as defined by the Family Code or related  
38 services.

39 [Sections 1454.053-1454.100 reserved for expansion]

1 SUBCHAPTER C. ENFORCEMENT

2 Revised Law

3 Sec. 1454.101. SANCTIONS AUTHORIZED. The sanctions  
4 authorized by Chapter 82 apply to a health benefit plan issuer that  
5 violates this chapter. (V.T.I.C. Art. 21.53N, Sec. 4(a) (part).)

6 Source Law

7 Sec. 4. (a) A health benefit plan as described  
8 by Section 2 of this article that is found to be in  
9 violation of or failing to comply with this article is  
10 subject to the sanctions authorized by Chapter 82 of  
11 this code. . . .

12 Revisor's Note

13 Section 4(a), V.T.I.C. Article 21.53N, refers to  
14 a health benefit plan that is found to be "in violation  
15 of or failing to comply" with this chapter. The  
16 revised law omits "failing to comply" as unnecessary  
17 because a plan that violates this chapter fails to  
18 comply with it.

19 Revised Law

20 Sec. 1454.102. CEASE AND DESIST PROCEDURES AND RESTITUTION  
21 FOR ATTORNEY'S FEES AUTHORIZED. The commissioner may use the cease  
22 and desist procedures authorized by Chapter 83 against a health  
23 benefit plan issuer that violates this chapter. In accordance with  
24 Chapter 83, the commissioner may order the health benefit plan  
25 issuer to make complete restitution for the violation, which may  
26 include restitution for the reasonable attorney's fees incurred by  
27 a person making a complaint under this chapter. (V.T.I.C.  
28 Art. 21.53N, Sec. 4(a) (part).)

29 Source Law

30 (a) . . . The commissioner may also use the  
31 cease and desist procedures authorized by Chapter 83  
32 of this code and, in accordance with the provisions of  
33 that chapter, direct the plan to make complete  
34 restitution, which may include reasonable attorney's  
35 fees incurred by a person making a complaint under this  
36 article. . . .

37 Revised Law

38 Sec. 1454.103. ADMINISTRATIVE PENALTIES AUTHORIZED. (a)  
39 In addition to any sanctions authorized by this subchapter, the

1 commissioner may impose an administrative penalty in accordance  
2 with Chapter 84 on a health benefit plan issuer that violates this  
3 chapter.

4 (b) On a finding that a health benefit plan issuer knowingly  
5 violated this chapter, the commissioner may impose in addition to  
6 the administrative penalty authorized by Section 84.022 an  
7 administrative penalty that does not exceed \$25,000. (V.T.I.C.  
8 Art. 21.53N, Sec. 4(b).)

9 Source Law

10 (b) In addition to imposing the sanctions  
11 authorized by Subsection (a) of this section, the  
12 commissioner may impose an administrative penalty in  
13 accordance with Chapter 84 of this code. Upon a  
14 finding that the plan knowingly violated the  
15 provisions of this article, the commissioner may  
16 impose an administrative penalty not to exceed \$25,000  
17 in addition to the penalty authorized by Section  
18 84.022 of this code.

19 Revised Law

20 Sec. 1454.104. AMOUNT OF DAMAGES. Notwithstanding this  
21 subchapter, in imposing a sanction or penalty for a violation of  
22 this chapter, the commissioner may order a health benefit plan  
23 issuer to pay the greater of complete or economic damages.  
24 (V.T.I.C. Art. 21.53N, Sec. 4(a) (part).)

25 Source Law

26 (a) . . . Notwithstanding the provisions of  
27 this section, the commissioner may order the greater  
28 of complete or economic damages.

29 Revised Law

30 Sec. 1454.105. APPLICABILITY OF CERTAIN PROCEDURAL  
31 REQUIREMENTS TO SANCTIONS OR ADMINISTRATIVE PENALTIES. Subchapter  
32 C, Chapter 84, applies to the imposition of a sanction or  
33 administrative penalty under this chapter. (V.T.I.C. Art. 21.53N,  
34 Sec. 4(d).)

35 Source Law

36 (d) The procedural requirements established by  
37 Subchapter C, Chapter 84 of this code, shall govern the  
38 imposition of sanctions and administrative penalties  
39 under this article.

Revised Law

Sec. 1454.106. INTERVENTION IN PROCEEDING. (a) In a proceeding relating to the imposition by the commissioner of a sanction or administrative penalty under this chapter, a person affected by an order of the commissioner, including a physician or health care provider, may intervene in the proceeding by filing a notice of intervention with the commissioner. The commissioner shall provide an affected person a reasonable period to intervene.

(b) At the time the commissioner notifies a health benefit plan issuer of the issuer's opportunity for a hearing regarding an alleged violation, the commissioner shall notify each affected person of all relevant information regarding the hearing.

(c) A person who intervenes under this section has the rights and powers of a party under Chapter 2001, Government Code. (V.T.I.C. Art. 21.53N, Sec. 4(e).)

## Source Law

(e) In any proceeding relating to the imposition of a sanction or administrative penalty by the commissioner under this article, any person affected by an order of the commissioner, including a physician or provider, is entitled to intervene in the proceeding by filing with the commissioner a notice of intervention. The commissioner shall afford an affected person, including a physician or provider, a reasonable period in which to intervene. At the time the commissioner notifies the health benefit plan about the plan's opportunity for a hearing regarding an alleged violation, the commissioner shall provide a notice to each affected person, including a physician or provider, of all relevant information regarding the hearing. An affected person, including a physician or provider who intervenes under this subsection, has the right and powers of a party under Chapter 2001, Government Code.

## Revised Law

Sec. 1454.107. TIME FOR COMMISSIONER'S DETERMINATION. Not later than the 120th day after the date a complaint alleging a violation of this chapter is filed with the department, the commissioner shall determine whether the alleged violation occurred and impose appropriate sanctions. (V.T.I.C. Art. 21.53N, Sec. 4(c).)

## Source Law

(c) The commissioner shall make a determination of a violation of this article and impose the appropriate sanctions within 120 days of the date a complaint alleging a violation is filed.

Revised Law

(b) The action must be commenced not later than the first anniversary of the date by which the commissioner is required to make a determination under Section 1454.107.

(1) impose the sanctions authorized by this subchapter or similar sanctions;

(3) award a claimant who prevails in an action filed under this section reasonable attorney's fees and court costs, including reasonable and necessary expert witness fees.

## Source Law

1 article, including an additional civil penalty of  
2 \$25,000 if the trier of fact finds that the defendant  
3 knowingly violated the provisions of this article. In  
4 addition, if the claimant prevails in the action, the  
5 court may award reasonable attorney's fees and court  
6 costs, including any reasonable and necessary expert  
7 witness fees.

8 (d) On a finding by the court that an action  
9 under Subsection (b) of this section was groundless  
10 and brought in bad faith or brought for the purpose of  
11 harassment, the court shall award the defendant  
12 reasonable and necessary attorney's fees.

13 Revised Law

14 Sec. 1454.109. APPEAL OF COMMISSIONER'S ORDER. (a) A  
15 person affected by an order of the commissioner regarding a  
16 violation of this chapter, including a person who intervenes under  
17 Section 1454.106, may file an appeal in district court.

18 (b) The standard of review for an appeal filed under this  
19 section is substantial evidence. (V.T.I.C. Art. 21.53N, Sec.  
20 5(a).)

21 Source Law

22 Sec. 5. (a) A person, including a person who  
23 intervenes under Section 4(e) of this article,  
24 affected by an order of the commissioner regarding a  
25 violation of this article may file an appeal in  
26 district court. The standard of review under this  
27 subsection is substantial evidence.

28 CHAPTER 1455. TELEMEDICINE AND TELEHEALTH

29	Sec. 1455.001. DEFINITIONS . . . . .	1134
30	Sec. 1455.002. APPLICABILITY OF CHAPTER . . . . .	1136
31	Sec. 1455.003. EXCEPTION. . . . .	1138
32	Sec. 1455.004. COVERAGE FOR TELEMEDICINE MEDICAL SERVICES	
33	AND TELEHEALTH SERVICES . . . . .	1139
34	Sec. 1455.005. RULES . . . . .	1139

35 CHAPTER 1455. TELEMEDICINE AND TELEHEALTH

36 Revised Law

37 Sec. 1455.001. DEFINITIONS. In this chapter:

38 (1) "Health professional" means:

39 (A) a physician;

40 (B) an individual who is:

41 (i) licensed or certified in this state to  
42 perform health care services; and

1 (ii) authorized to assist a physician in  
2 providing telemedicine medical services that are delegated and  
3 supervised by the physician; or

4 (C) a licensed or certified health professional  
5 acting within the scope of the license or certification who does not  
6 perform a telemedicine medical service.

7 (2) "Physician" means a person licensed to practice  
8 medicine in this state under Subtitle B, Title 3, Occupations Code.

9 (3) "Telehealth service" and "telemedicine medical  
10 service" have the meanings assigned by Section 57.042, Utilities  
11 Code. (V.T.I.C. Art. 21.53F, Secs. 1(2), (3), (4), (5), as added  
12 Acts 75th Leg., R.S., Ch. 880.)

13 Source Law

14 Art. 21.53F  
15 Sec. 1. In this article:

16 (2) "Health professional" means:  
17 (A) a physician;  
18 (B) an individual who is:  
19 (i) licensed or certified in  
20 this state to perform health care services; and  
21 (ii) authorized to assist a  
22 physician in providing telemedicine medical services  
23 that are delegated and supervised by the physician; or  
24 (C) a licensed or certified health  
25 professional acting within the scope of the license or  
26 certification who does not perform a telemedicine  
27 medical service.  
28 (3) "Physician" means a person licensed to  
29 practice medicine in this state under Subtitle B,  
30 Title 3, Occupations Code.  
31 (4) "Telehealth service" has the meaning  
32 assigned by Section 57.042, Utilities Code.  
33 (5) "Telemedicine medical service" has the  
34 meaning assigned by Section 57.042, Utilities Code.

35 Revisor's Note

36 Section 1(1), V.T.I.C. Article 21.53F, as added  
37 by Chapter 880, Acts of the 75th Legislature, Regular  
38 Session, 1997, defines "health benefit plan." The  
39 revised law omits the definition as unnecessary  
40 because Section 2 of that article, revised as Sections  
41 1455.002 and 1455.003, specifies the types of health  
42 benefit plans to which this chapter applies, and thus  
43 the defined term is not helpful to the reader. The

omitted law reads:

(1) "Health benefit plan" means  
a plan described by Section 2 of this  
article.

Revised Law

Sec. 1455.002. APPLICABILITY OF CHAPTER. This chapter  
applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses  
incurred as a result of a health condition, accident, or sickness,  
including:

(A) an individual, group, blanket, or franchise  
insurance policy or insurance agreement, a group hospital service  
contract, or an individual or group evidence of coverage that is  
offered by:

(i) an insurance company;

(ii) a group hospital service corporation  
operating under Chapter 842;

(iii) a fraternal benefit society operating  
under Chapter 885;

(iv) a stipulated premium company operating  
under Chapter 884; or

(v) a health maintenance organization  
operating under Chapter 843; and

(B) to the extent permitted by the Employee  
Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et  
seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement  
as defined by Section 3 of that Act; or

(ii) another analogous benefit  
arrangement; or

(2) is offered by an approved nonprofit health  
corporation that holds a certificate of authority under Chapter  
844. (V.T.I.C. Art. 21.53F, Sec. 2(a), as added Acts 75th Leg.,  
R.S., Ch. 880.)



1 of authority. The revised law also omits as  
2 unnecessary the reference to the commissioner issuing  
3 the certificate of authority because Chapter 844  
4 requires the commissioner to issue the certificate of  
5 authority.

6 Revised Law

7 Sec. 1455.003. EXCEPTION. This chapter does not apply to:

8 (1) a plan that provides coverage:

9 (A) only for a specified disease;

10 (B) only for accidental death or dismemberment;

11 (C) for wages or payments in lieu of wages for a  
12 period during which an employee is absent from work because of  
13 sickness or injury; or

14 (D) as a supplement to a liability insurance  
15 policy;

16 (2) a small employer health benefit plan written under  
17 Chapter 1501;

18 (3) a Medicare supplemental policy as defined by  
19 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

20 (4) a workers' compensation insurance policy;

21 (5) medical payment insurance coverage provided under  
22 a motor vehicle insurance policy; or

23 (6) a long-term care insurance policy, including a  
24 nursing home fixed indemnity policy, unless the commissioner  
25 determines that the policy provides benefit coverage so  
26 comprehensive that the policy is a health benefit plan as described  
27 by Section 1455.002. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added  
28 Acts 75th Leg., R.S., Ch. 880.)

29 Source Law

30 (b) This article does not apply to:

31 (1) a plan that provides coverage:

32 (A) only for a specified disease;

33 (B) only for accidental death or  
34 dismemberment;

35 (C) for wages or payments in lieu of  
36 wages for a period during which an employee is absent  
37 from work because of sickness or injury; or

38 (D) as a supplement to liability

1 insurance;  
2 (2) a small employer health benefit plan  
3 written under Chapter 26 of this code;  
4 (3) a Medicare supplemental policy as  
5 defined by Section 1882(g)(1), Social Security Act (42  
6 U.S.C. Section 1395ss);  
7 (4) workers' compensation insurance  
8 coverage;  
9 (5) medical payment insurance issued as  
10 part of a motor vehicle insurance policy; or  
11 (6) a long-term care policy, including a  
12 nursing home fixed indemnity policy, unless the  
13 commissioner determines that the policy provides  
14 benefit coverage so comprehensive that the policy is a  
15 health benefit plan as described by Subsection (a) of  
16 this section.

17 Revised Law

18 Sec. 1455.004. COVERAGE FOR TELEMEDICINE MEDICAL SERVICES  
19 AND TELEHEALTH SERVICES. (a) A health benefit plan may not  
20 exclude a telemedicine medical service or a telehealth service from  
21 coverage under the plan solely because the service is not provided  
22 through a face-to-face consultation.

23 (b) A health benefit plan may require a deductible, a  
24 copayment, or coinsurance for a telemedicine medical service or a  
25 telehealth service. The amount of the deductible, copayment, or  
26 coinsurance may not exceed the amount of the deductible, copayment,  
27 or coinsurance required for a comparable medical service provided  
28 through a face-to-face consultation. (V.T.I.C. Art. 21.53F, Sec.  
29 3, as added Acts 75th Leg., R.S., Ch. 880.)

30 Source Law

31 Sec. 3. (a) A health benefit plan may not  
32 exclude a telemedicine medical service or a telehealth  
33 service from coverage under the plan solely because  
34 the service is not provided through a face-to-face  
35 consultation.

36 (b) Benefits required under this article may be  
37 made subject to a deductible, copayment, or  
38 coinsurance requirement. A deductible, copayment, or  
39 coinsurance applicable to a particular service  
40 provided through telemedicine medical services or  
41 telehealth services may not exceed the deductible,  
42 copayment, or coinsurance required by the health  
43 benefit plan for a comparable medical service provided  
44 through a face-to-face consultation.

45 Revised Law

46 Sec. 1455.005. RULES. Subject to Section 107.004,  
47 Occupations Code, the commissioner may adopt rules necessary to  
48 implement this chapter. (V.T.I.C. Art. 21.53F, Sec. 6(a), as added

1 Acts 75th Leg., R.S., Ch. 880.)

2 Source Law

3 Sec. 6. (a) Subject to Subsection (b) of this  
4 section, the commissioner may adopt rules as necessary  
5 to implement this article.

6 [Chapters 1456-1500 reserved for expansion]

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17       CHAPTER 1501. HEALTH INSURANCE PORTABILITY AND AVAILABILITY ACT

18               SUBCHAPTER A. GENERAL PROVISIONS

19                               Revised Law

20               Sec. 1501.001.   SHORT TITLE.   This chapter may be cited as

21   the Health Insurance Portability and Availability Act.   (V.T.I.C.

22   Art. 26.01.)

23                               Source Law

24               Art. 26.01. This chapter may be cited as the

25   Health Insurance Portability and Availability Act.

26                               Revised Law

27               Sec. 1501.002.   DEFINITIONS.   In this chapter:

28               (1)   "Agent" means a person who may act as an agent for

29   the sale of a health benefit plan under a license issued under Title

30   13.

31               (2)   "Dependent" means:

32                    (A)   a spouse;

33                    (B)   a child younger than 25 years of age,

34   including a newborn child;

1 (C) a child of any age who is:  
2 (i) medically certified as disabled; and  
3 (ii) dependent on the parent;  
4 (D) an individual who must be covered under:  
5 (i) Section 1251.154; or  
6 (ii) Section 1201.062; and  
7 (E) any other child eligible under an employer's  
8 health benefit plan, including a child described by Section  
9 1503.003.

10 (3) "Eligible employee" means an employee who works on  
11 a full-time basis and who usually works at least 30 hours a week.  
12 The term includes a sole proprietor, a partner, and an independent  
13 contractor, if the individual is included as an employee under a  
14 health benefit plan of a small or large employer. The term does not  
15 include an employee who:

16 (A) works on a part-time, temporary, seasonal, or  
17 substitute basis;

18 (B) is covered under:  
19 (i) another health benefit plan; or  
20 (ii) a self-funded or self-insured employee  
21 welfare benefit plan that provides health benefits and is  
22 established in accordance with the Employee Retirement Income  
23 Security Act of 1974 (29 U.S.C. Section 1001 et seq.); or

24 (C) elects not to be covered under the employer's  
25 health benefit plan and is covered under:

26 (i) the Medicaid program;  
27 (ii) another federal program, including the  
28 CHAMPUS program or Medicare program; or  
29 (iii) a benefit plan established in another  
30 country.

31 (4) "Employee" means an individual employed by an  
32 employer.

33 (5) "Health benefit plan" means a group, blanket, or  
34 franchise insurance policy, a certificate issued under a group

1 policy, a group hospital service contract, or a group subscriber  
2 contract or evidence of coverage issued by a health maintenance  
3 organization that provides benefits for health care services. The  
4 term does not include:

5 (A) accident-only or disability income insurance  
6 coverage or a combination of accident-only and disability income  
7 insurance coverage;

8 (B) credit-only insurance coverage;

9 (C) disability insurance coverage;

10 (D) coverage for a specified disease or illness;

11 (E) Medicare services under a federal contract;

12 (F) Medicare supplement and Medicare Select  
13 benefit plans regulated in accordance with federal law;

14 (G) long-term care coverage or benefits, nursing  
15 home care coverage or benefits, home health care coverage or  
16 benefits, community-based care coverage or benefits, or any  
17 combination of those coverages or benefits;

18 (H) coverage that provides limited-scope dental  
19 or vision benefits;

20 (I) coverage provided by a single service health  
21 maintenance organization;

22 (J) workers' compensation insurance coverage or  
23 similar insurance coverage;

24 (K) coverage provided through a jointly managed  
25 trust authorized under 29 U.S.C. Section 141 et seq. that contains a  
26 plan of benefits for employees that is negotiated in a collective  
27 bargaining agreement governing wages, hours, and working  
28 conditions of the employees that is authorized under 29 U.S.C.  
29 Section 157;

30 (L) hospital indemnity or other fixed indemnity  
31 insurance coverage;

32 (M) reinsurance contracts issued on a stop-loss,  
33 quota-share, or similar basis;

34 (N) short-term major medical contracts;

1 (O) liability insurance coverage, including  
2 general liability insurance coverage and automobile liability  
3 insurance coverage, and coverage issued as a supplement to  
4 liability insurance coverage, including automobile medical payment  
5 insurance coverage;

6 (P) coverage for on-site medical clinics;

7 (Q) coverage that provides other limited  
8 benefits specified by federal regulations; or

9 (R) other coverage that:

10 (i) is similar to the coverage described by  
11 this subdivision under which benefits for medical care are  
12 secondary or incidental to other coverage benefits; and

13 (ii) is specified by federal regulations.

14 (6) "Health benefit plan issuer" means an entity  
15 authorized under this code or another insurance law of this state  
16 that provides health insurance or health benefits in this state,  
17 including:

18 (A) an insurance company;

19 (B) a group hospital service corporation  
20 operating under Chapter 842;

21 (C) a health maintenance organization operating  
22 under Chapter 843; and

23 (D) a stipulated premium company operating under  
24 Chapter 884.

25 (7) "Health status related factor" means:

26 (A) health status;

27 (B) medical condition, including both physical  
28 and mental illness;

29 (C) claims experience;

30 (D) receipt of health care;

31 (E) medical history;

32 (F) genetic information;

33 (G) evidence of insurability, including  
34 conditions arising out of acts of family violence; and

1 (H) disability.

2 (8) "Large employer" means a person who employed an  
3 average of at least 51 eligible employees on business days during  
4 the preceding calendar year and who employs at least two employees  
5 on the first day of the plan year. The term includes a governmental  
6 entity subject to Article 3.51-1, 3.51-2, 3.51-4, or 3.51-5, to  
7 Subchapter C, Chapter 1364, or to Chapter 1578 that otherwise meets  
8 the requirements of this subdivision. For purposes of this  
9 definition, a partnership is the employer of a partner.

10 (9) "Large employer health benefit plan" means a  
11 health benefit plan offered to a large employer.

12 (10) "Large employer health benefit plan issuer" means  
13 a health benefit plan issuer, to the extent that the issuer is  
14 offering, delivering, issuing for delivery, or renewing health  
15 benefit plans subject to Subchapters C and M.

16 (11) "Person" means an individual, corporation,  
17 partnership, or other legal entity.

18 (12) "Preexisting condition provision" means a  
19 provision that excludes or limits coverage as to a disease or  
20 condition for a specified period after the effective date of  
21 coverage.

22 (13) "Premium" means all amounts paid by a small or  
23 large employer and eligible employees as a condition of receiving  
24 coverage from a small or large employer health benefit plan issuer,  
25 including any fees or other contributions associated with a health  
26 benefit plan.

27 (14) "Small employer" means a person who employed an  
28 average of at least two employees but not more than 50 eligible  
29 employees on business days during the preceding calendar year and  
30 who employs at least two employees on the first day of the plan  
31 year. The term includes a governmental entity subject to Article  
32 3.51-1, 3.51-2, 3.51-4, or 3.51-5, to Subchapter C, Chapter 1364,  
33 or to Chapter 1578 that otherwise meets the requirements of this  
34 subdivision. For purposes of this definition, a partnership is the

1 employer of a partner.

2 (15) "Small employer health benefit plan" means a  
3 health benefit plan developed by the commissioner under Subchapter  
4 F or any other health benefit plan offered to a small employer in  
5 accordance with Section 1501.252(c) or 1501.255.

6 (16) "Small employer health benefit plan issuer" means  
7 a health benefit plan issuer, to the extent that the issuer is  
8 offering, delivering, issuing for delivery, or renewing health  
9 benefit plans subject to Subchapters C-H.

10 (17) "Waiting period" means a period established by an  
11 employer that must elapse before an individual who is a potential  
12 enrollee in a health benefit plan is eligible to be covered for  
13 benefits. (V.T.I.C. Art. 26.02, Subdivs. (2), (8), (9), (10), (11),  
14 (12), (13), (15), (16), (17), (21), (24), (25); Art. 26.02,  
15 Subdivs. (30), (31), (32), (34), as amended Acts 77th Leg., R.S.,  
16 Ch. 823; Art. 26.02, Subdivs. (29), (30), (31), (33), as amended  
17 Acts 77th Leg., R.S., Ch. 608.)

18 Source Law

19 Art. 26.02. In this chapter:

20 (2) "Agent" means a person who may act as  
21 an agent for the sale of a health benefit plan under a  
22 license issued under Section 15 or 15A, Texas Health  
23 Maintenance Organization Act (Article 20A.15 or  
24 20A.15A, Vernon's Texas Insurance Code), or under  
25 Subchapter A, Chapter 21, of this code.

26 (8) "Dependent" means:  
27 (A) a spouse;  
28 (B) a newborn child;  
29 (C) a child younger than 25 years of  
30 age;  
31 (D) a child of any age who is  
32 medically certified as disabled and dependent on the  
33 parent;  
34 (E) any person who must be covered  
35 under:  
36 (i) Section 3D or 3E, Article  
37 3.51-6, of this code; or  
38 (ii) Section 2(L), Chapter 397,  
39 Acts of the 54th Legislature, Regular Session, 1955  
40 (Article 3.70-2, Vernon's Texas Insurance Code); and  
41 (F) any other child eligible under an  
42 employer's benefit plan, including a child described  
43 by Section 3, Article 21.24-2, of this code.

44 (9) "Eligible employee" means an employee  
45 who works on a full-time basis and who usually works at  
46 least 30 hours a week. The term also includes a sole  
47 proprietor, a partner, and an independent contractor,

1 if the sole proprietor, partner, or independent  
2 contractor is included as an employee under a health  
3 benefit plan of a small or large employer. The term  
4 does not include:

5 (A) an employee who works on a  
6 part-time, temporary, seasonal, or substitute basis;  
7 or

8 (B) an employee who is covered under:  
9 (i) another health benefit  
10 plan;

11 (ii) a self-funded or  
12 self-insured employee welfare benefit plan that  
13 provides health benefits and that is established in  
14 accordance with the Employee Retirement Income  
15 Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

16 (iii) the Medicaid program if  
17 the employee elects not to be covered;

18 (iv) another federal program,  
19 including the CHAMPUS program or Medicare program, if  
20 the employee elects not to be covered; or

21 (v) a benefit plan established  
22 in another country if the employee elects not to be  
23 covered.

24 (10) "Employee" means any individual  
25 employed by an employer.

26 (11) "Health benefit plan" means a group,  
27 blanket, or franchise insurance policy, a certificate  
28 issued under a group policy, a group hospital service  
29 contract, or a group subscriber contract or evidence  
30 of coverage issued by a health maintenance  
31 organization that provides benefits for health care  
32 services. The term does not include:

33 (A) accident-only or disability  
34 income insurance or a combination of accident-only and  
35 disability income insurance;

36 (B) credit-only insurance;

37 (C) disability insurance coverage;

38 (D) coverage for a specified disease  
39 or illness;

40 (E) Medicare services under a federal  
41 contract;

42 (F) Medicare supplement and Medicare  
43 Select policies regulated in accordance with federal  
44 law;

45 (G) long-term care coverage or  
46 benefits, nursing home care coverage or benefits, home  
47 health care coverage or benefits, community-based care  
48 coverage or benefits, or any combination of those  
49 coverages or benefits;

50 (H) coverage that provides  
51 limited-scope dental or vision benefits;

52 (I) coverage provided by a single  
53 service health maintenance organization;

54 (J) coverage issued as a supplement  
55 to liability insurance;

56 (K) workers' compensation or similar  
57 insurance;

58 (L) automobile medical payment  
59 insurance coverage;

60 (M) jointly managed trusts  
61 authorized under 29 U.S.C. Section 141 et seq. that  
62 contain a plan of benefits for employees that is  
63 negotiated in a collective bargaining agreement  
64 governing wages, hours, and working conditions of the  
65 employees that is authorized under 29 U.S.C. Section  
66 157;

67 (N) hospital indemnity or other fixed  
68 indemnity insurance;

(O) reinsurance contracts issued on a stop-loss, quota-share, or similar basis;

(P) short-term major medical contracts;

(Q) liability insurance, including general liability insurance and automobile liability insurance;

(R) other coverage that is:

(i) similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits; and

(ii) specified in federal regulations;

(S) coverage for on-site medical clinics; or

(T) coverage that provides other limited benefits specified by federal regulations.

(12) "Health carrier" means any entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including an insurance company, a group hospital service corporation under Chapter 20 of this code, a health maintenance organization under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), and a stipulated premium company under Chapter 22 of this code.

(13) "Health status related factor" means:

(A) health status;

(B) medical condition, including both physical and mental illness;

(C) claims experience;

(D) receipt of health care;

(E) medical history;

(F) genetic information;

(G) evidence of insurability, including conditions arising out of acts of family violence; and

(H) disability.

(15) "Large employer" means an employer who employed an average of at least 51 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. For purposes of this definition, a partnership is the employer of a partner. A large employer includes a governmental entity subject to Section 1, Chapter 123, Acts of the 60th Legislature, Regular Session, 1967 (Article 3.51-3, Vernon's Texas Insurance Code), or Article 3.51-1, 3.51-2, 3.51-4, 3.51-5, or 3.51-5A of this code that otherwise meets the requirements of this section.

(16) "Large employer carrier" means a health carrier, to the extent that carrier is offering, delivering, issuing for delivery, or renewing health benefit plans subject to Subchapter H of this chapter.

(17) "Large employer health benefit plan" means a health benefit plan offered to a large employer.

(21) "Person" means an individual, corporation, partnership, or other legal entity.

(24) "Preexisting condition provision" means a provision that denies, excludes, or limits

1 coverage as to a disease or condition for a specified  
2 period after the effective date of coverage.

3 (25) "Premium" means all amounts paid by a  
4 small or large employer and eligible employees as a  
5 condition of receiving coverage from a small or large  
6 employer carrier, including any fees or other  
7 contributions associated with a health benefit plan.

8 Art. 26.02. [as amended Acts 77th Leg., R.S., Ch.  
9 823] In this chapter:

10 (30) "Small employer" means an employer  
11 who employed an average of at least two but not more  
12 than 50 eligible employees on business days during the  
13 preceding calendar year and who employs at least two  
14 eligible employees on the first day of the plan year.  
15 For purposes of this definition, a partnership is the  
16 employer of a partner. A small employer includes a  
17 governmental entity subject to Section 1, Chapter 123,  
18 Acts of the 60th Legislature, Regular Session, 1967  
19 (Article 3.51-3, Vernon's Texas Insurance Code), or  
20 Article 3.51-1, 3.51-2, 3.51-4, 3.51-5, or 3.51-5A of  
21 this code that otherwise meets the requirements of  
22 this section and elects to be treated as a small  
23 employer.

24 (31) "Small employer carrier" means a  
25 health carrier, to the extent that that carrier is  
26 offering, delivering, issuing for delivery, or  
27 renewing health benefit plans subject to Subchapters  
28 C-G of this chapter under Article 26.06(a) of this  
29 code.

30 (32) "Small employer health benefit plan"  
31 means a plan developed by the commissioner under  
32 Subchapter E of this chapter or any other health  
33 benefit plan offered to a small employer in accordance  
34 with Article 26.42(c) or 26.48 of this code.

35 (34) "Waiting period" means a period  
36 established by an employer that must pass before an  
37 individual who is a potential enrollee in a health  
38 benefit plan is eligible to be covered for benefits.

39 Art. 26.02. [as amended Acts 77th Leg., R.S.,  
40 Ch. 608] In this chapter:

41 (29) "Small employer" means an employer  
42 who employed an average of at least two employees but  
43 not more than 50 eligible employees on business days  
44 during the preceding calendar year and who employs at  
45 least two employees on the first day of the plan year.  
46 For purposes of this definition, a partnership is the  
47 employer of a partner. A small employer includes a  
48 governmental entity subject to Section 1, Chapter 123,  
49 Acts of the 60th Legislature, Regular Session, 1967  
50 (Article 3.51-3, Vernon's Texas Insurance Code), or  
51 Article 3.51-1, 3.51-2, 3.51-4, 3.51-5, or 3.51-5A of  
52 this code that otherwise meets the requirements of  
53 this section.

54 (30) "Small employer carrier" means a  
55 health carrier, to the extent that that carrier is  
56 offering, delivering, issuing for delivery, or  
57 renewing health benefit plans subject to Subchapters  
58 C-G of this chapter under Article 26.06(a) of this  
59 code.

60 (31) "Small employer health benefit plan"  
61 means a plan developed by the commissioner under  
62 Subchapter E of this chapter or any other health  
63 benefit plan offered to a small employer in accordance

1 with Article 26.42(c) or 26.48 of this code.

2 (33) "Waiting period" means a period  
3 established by an employer that must pass before an  
4 individual who is a potential enrollee in a health  
5 benefit plan is eligible to be covered for benefits.

6 Revisor's Note

7 (1) Subdivision (2), V.T.I.C. Article 26.02,  
8 defines "agent" as a person "who may act as an agent  
9 for the sale of a health benefit plan under a license  
10 issued under Section 15 or 15A, Texas Health  
11 Maintenance Organization Act (Article 20A.15 or  
12 20A.15A, Vernon's Texas Insurance Code), or under  
13 Subchapter A, Chapter 21, of this code." The revised  
14 law omits the references to Articles 20A.15 and  
15 20A.15A because those sections were repealed by  
16 Chapter 716, Acts of the 75th Legislature, Regular  
17 Session, 1997; that act also prohibited the issuance  
18 or renewal of a license under those sections after  
19 December 31, 1997.

20 (2) Subdivision (8)(E), V.T.I.C. Article 26.02,  
21 defines "dependent" to include "any person who must be  
22 covered under . . . Section 3D or 3E, Article 3.51-6,  
23 of this code; or . . . Section 2(L), Chapter 397, Acts  
24 of the 54th Legislature, Regular Session, 1955  
25 (Article 3.70-2, Vernon's Texas Insurance Code)."  
26 Because the reference to Subsection (L), Article  
27 3.70-2, revised as Section 1201.062 of this code,  
28 includes the persons described by Section 3E, Article  
29 3.51-6, revised as Section 1251.151 of this code, the  
30 revised law omits the reference to the latter  
31 provision.

32 (3) Subdivision (11)(F), V.T.I.C. Article  
33 26.02, excludes "Medicare supplement and Medicare  
34 Select policies" from the definition of "health  
35 benefit plan." The revised law substitutes "Medicare  
36 supplement and Medicare Select benefit plans" for

1 "Medicare supplement and Medicare Select policies"  
2 because federal and state law permit Medicare  
3 supplement and Medicare Select benefits to be provided  
4 through health maintenance organizations, which are  
5 not insurers. Consequently, "benefit plan" is a more  
6 accurate term than "policy."

7 (4) Subdivision (12), V.T.I.C. Article 26.02,  
8 defines "health carrier." Subdivision (16), V.T.I.C.  
9 Article 26.02, defines "large employer carrier."  
10 Subdivision (31), V.T.I.C. Article 26.02, as amended  
11 by Chapter 823, Acts of the 77th Legislature, Regular  
12 Session, 2001, and Subdivision (30), V.T.I.C. Article  
13 26.02, as amended by Chapter 608, Acts of the 77th  
14 Legislature, Regular Session, 2001, define "small  
15 employer carrier." "Carrier" is a term used in  
16 conjunction with traditional insurance. Included  
17 within the definition of "health carrier" are entities  
18 such as health maintenance organizations that are not  
19 insurers. Consequently, "benefit plan issuer" is a  
20 more accurate term than "carrier," and the revised law  
21 substitutes "health benefit plan issuer" for "health  
22 carrier," "large employer health benefit plan issuer"  
23 for "large employer carrier," and "small employer  
24 health benefit plan issuer" for "small employer  
25 carrier." These changes, as well as any comparable  
26 changes necessary to ensure consistent terminology,  
27 are made throughout this chapter.

28 (5) Subdivision (24), V.T.I.C. Article 26.02,  
29 refers to a provision that "denies, excludes, or  
30 limits" coverage. The reference to "denies" is  
31 omitted from the revised law because in this context  
32 "denies" is included within the meaning of "excludes."

33 Revised Law

34 Sec. 1501.003. APPLICABILITY: SMALL EMPLOYER HEALTH

1 BENEFIT PLANS. An individual or group health benefit plan is a  
2 small employer health benefit plan subject to Subchapters C-H if it  
3 provides health care benefits covering two or more eligible  
4 employees of a small employer and:

5 (1) the employer pays a portion of the premium or  
6 benefits;

7 (2) the employer or a covered individual treats the  
8 health benefit plan as part of a plan or program for purposes of  
9 Section 106 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section  
10 106 or 162); or

11 (3) the health benefit plan is an employee welfare  
12 benefit plan under 29 C.F.R. Section 2510.3-1(j). (V.T.I.C.  
13 Art. 26.06, Subsec. (a).)

14 Source Law

15 Art. 26.06. (a) An individual or group health  
16 benefit plan is subject to Subchapters C-G of this  
17 chapter if it provides health care benefits covering  
18 two or more eligible employees of a small employer and  
19 if:

20 (1) a portion of the premium or benefits is  
21 paid by a small employer;

22 (2) the health benefit plan is treated by  
23 the employer or by a covered individual as part of a  
24 plan or program for the purposes of Section 106 or 162,  
25 Internal Revenue Code of 1986 (26 U.S.C. Section 106 or  
26 162); or

27 (3) the health benefit plan is an employee  
28 welfare benefit plan under 29 C.F.R. Section  
29 2510.3-1(j).

30 Revised Law

31 Sec. 1501.004. APPLICABILITY: LARGE EMPLOYER HEALTH  
32 BENEFIT PLANS. An individual or group health benefit plan is a  
33 large employer health benefit plan subject to Subchapters C and M if  
34 the plan provides health care benefits to eligible employees of a  
35 large employer and:

36 (1) the employer pays a portion of the premium or  
37 benefits;

38 (2) the employer or a covered individual treats the  
39 health benefit plan as part of a plan or program for purposes of  
40 Section 106 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section  
41 106 or 162); or

1 (3) the health benefit plan is an employee welfare  
2 benefit plan under 29 C.F.R. Section 2510.3-1(j). (V.T.I.C.  
3 Art. 26.81, Subsec. (a).)

4 Source Law

5 Art. 26.81. (a) An individual or group health  
6 benefit plan is subject to this subchapter if the plan  
7 provides health care benefits to eligible employees of  
8 a large employer and if:

9 (1) a portion of the premium or benefits is  
10 paid by a large employer;

11 (2) the health benefit plan is treated by  
12 the employer or by a covered individual as part of a  
13 plan or program for the purposes of Section 106 or 162,  
14 Internal Revenue Code of 1986 (26 U.S.C. Section 106 or  
15 162); or

16 (3) the health benefit plan is an employee  
17 welfare benefit plan under 29 C.F.R. Section  
18 2510.3-1(j).

19 Revised Law

20 Sec. 1501.005. EXCEPTION: CERTAIN INDIVIDUALLY  
21 UNDERWRITTEN POLICIES. Except as provided by Section 1501.003 or  
22 1501.004, this chapter does not apply to an individual health  
23 insurance policy that is subject to individual underwriting, even  
24 if the premium is paid through a payroll deduction method.  
25 (V.T.I.C. Art. 26.06, Subsec. (c); Art. 26.81, Subsec. (c).)

26 Source Law

27 [Art. 26.06]

28 (c) Except as provided by Subsection (a) of this  
29 article, this chapter does not apply to an individual  
30 health insurance policy that is subject to individual  
31 underwriting, even if the premium is remitted through  
32 a payroll deduction method.

33 [Art. 26.81]

34 (c) Except as provided by Subsection (a) of this  
35 article, this subchapter does not apply to an  
36 individual health insurance policy that is subject to  
37 individual underwriting, even if the premium is  
38 remitted through payroll deduction.

39 Revised Law

40 Sec. 1501.006. CERTIFICATION. (a) In accordance with  
41 rules adopted by the commissioner, each health benefit plan issuer  
42 shall certify that the issuer is offering, delivering, issuing for  
43 delivery, or renewing, or that the issuer intends to offer,  
44 deliver, issue for delivery, or renew:

45 (1) a health benefit plan to or through a small

1 employer in this state that is subject to this chapter; or

2 (2) a health benefit plan to or through a large  
3 employer in this state that is subject to this chapter.

4 (b) A health benefit plan issuer must submit a revised  
5 certification to the commissioner only if the issuer changes its  
6 status as a small or large employer health benefit plan issuer or  
7 changes its intent to become a small or large employer health  
8 benefit plan issuer to the extent that its previous certification  
9 ceases to be accurate.

10 (c) The certification must include a statement that the  
11 health benefit plan issuer is complying with this chapter to the  
12 extent it applies to the issuer. (V.T.I.C. Arts. 26.07, 26.82.)

13 Source Law

14 Art. 26.07. (a) Each health carrier shall  
15 certify, in accordance with rules adopted by the  
16 commissioner, that the health carrier is offering,  
17 delivering, issuing for delivery, or renewing, or that  
18 the health carrier intends to offer, deliver, issue  
19 for delivery, or renew a health benefit plan to or  
20 through a small employer in this state that is subject  
21 to this chapter under Article 26.06(a) of this code.

22 (b) A health carrier must submit a revised  
23 certification to the commissioner only if the health  
24 carrier changes its status as a small employer carrier  
25 or changes its intent to become a small employer health  
26 carrier to the extent that its previous certification  
27 ceases to be accurate.

28 (c) The certification shall include a statement  
29 that the health carrier is complying with this chapter  
30 to the extent it is applicable to the carrier.

31 Art. 26.82. (a) Each health carrier shall  
32 certify, in accordance with rules adopted by the  
33 commissioner, that the health carrier is offering,  
34 delivering, issuing for delivery, or renewing, or that  
35 the health carrier intends to offer, deliver, issue  
36 for delivery, or renew a health benefit plan to or  
37 through a large employer in this state that is subject  
38 to this subchapter under Article 26.81 of this code.

39 (b) A health carrier must submit a revised  
40 certification to the commissioner only if the health  
41 carrier changes its status as a large employer carrier  
42 or changes its intent to become a small employer health  
43 carrier to the extent that its previous certification  
44 ceases to be accurate.

45 (c) The certification shall include a statement  
46 that the health carrier is complying with this chapter  
47 to the extent it is applicable to the carrier.

48 Revised Law

49 Sec. 1501.007. AFFILIATES. (a) In this section,  
50 "affiliate" has the meaning described by Section 823.003.

1 (b) For purposes of this chapter, health benefit plan  
2 issuers that are affiliates or that are eligible to file a  
3 consolidated tax return are considered to be one issuer, and a  
4 restriction imposed by this chapter applies as if the health  
5 benefit plans delivered or issued for delivery to small employers  
6 in this state by the affiliates were issued by one issuer.

7 (c) Notwithstanding Subsection (b), a health maintenance  
8 organization that is an affiliate is considered to be a separate  
9 health benefit plan issuer for purposes of this chapter. (V.T.I.C.  
10 Art. 26.03.)

#### 11 Source Law

12 Art. 26.03. (a) For purposes of this chapter,  
13 health carriers that are affiliates or that are  
14 eligible to file a consolidated tax return are  
15 considered to be one carrier, and a restriction  
16 imposed by this chapter applies as if the health  
17 benefit plans delivered or issued for delivery to  
18 small employers in this state by the affiliates were  
19 issued by one carrier.

20 (b) An affiliate that is a health maintenance  
21 organization is considered to be a separate health  
22 carrier for purposes of this chapter.

23 (c) In this article, "affiliate" has the meaning  
24 assigned by Article 21.49-1 of this code.

#### 25 Revised Law

26 Sec. 1501.008. LATE ENROLLEES. (a) For purposes of this  
27 chapter, an employee or dependent eligible for enrollment in a  
28 small or large employer's health benefit plan is a late enrollee if  
29 the individual requests enrollment after the expiration of:

30 (1) the initial enrollment period established under  
31 the terms of the first plan for which the individual was eligible  
32 through the small or large employer; or

33 (2) an open enrollment period under Section  
34 1501.156(a) or 1501.606(a).

35 (b) An employee or dependent eligible for enrollment is not  
36 a late enrollee if the individual:

37 (1) was covered under another health benefit plan or  
38 self-funded employer health benefit plan at the time the individual  
39 was eligible to enroll;

40 (2) declined enrollment in writing, at the time of the

1 initial eligibility for enrollment, stating that coverage under  
2 another health benefit plan or self-funded employer health benefit  
3 plan was the reason for declining enrollment;

4 (3) has lost coverage under the other health benefit  
5 plan or self-funded employer health benefit plan as a result of:

6 (A) the termination of employment;

7 (B) a reduction in the number of hours of  
8 employment;

9 (C) the termination of the other plan's coverage;

10 (D) the termination of contributions toward the  
11 premium made by the employer; or

12 (E) the death of a spouse or divorce; and

13 (4) requests enrollment not later than the 31st day  
14 after the date coverage under the other health benefit plan or  
15 self-funded employer health benefit plan terminates.

16 (c) An employee or dependent eligible for enrollment is also  
17 not a late enrollee if the individual is:

18 (1) employed by an employer that offers multiple  
19 health benefit plans and the individual elects a different health  
20 benefit plan during an open enrollment period;

21 (2) a spouse for whom a court has ordered coverage  
22 under a covered employee's plan and the request for enrollment of  
23 the spouse is made not later than the 31st day after the date the  
24 court order is issued;

25 (3) a child for whom a court has ordered coverage under  
26 a covered employee's plan and the request for enrollment is made not  
27 later than the 31st day after the date the employer receives the  
28 court order; or

29 (4) a child of a covered employee who has lost coverage  
30 under Title XIX of the Social Security Act (42 U.S.C. Section 1396  
31 et seq.), other than coverage consisting solely of benefits under  
32 Section 1928 of that Act (42 U.S.C. Section 1396s), or under Chapter  
33 62, Health and Safety Code, and the request for enrollment is made  
34 not later than the 31st day after the date on which the child loses

1 coverage. (V.T.I.C. Art. 26.02, Subdiv. (18).)

2 Source Law

3 Art. 26.02. In this chapter:

4 (18) "Late enrollee" means any employee or  
5 dependent eligible for enrollment who requests  
6 enrollment in a small or large employer's health  
7 benefit plan after the expiration of the initial  
8 enrollment period established under the terms of the  
9 first plan for which that employee or dependent was  
10 eligible through the small or large employer or after  
11 the expiration of an open enrollment period under  
12 Article 26.21(h) or 26.83 of this code. An employee or  
13 dependent eligible for enrollment is not a late  
14 enrollee if:

15 (A) the individual:

16 (i) was covered under another  
17 health benefit plan or self-funded employer health  
18 benefit plan at the time the individual was eligible to  
19 enroll;

20 (ii) declines in writing, at  
21 the time of the initial eligibility, stating that  
22 coverage under another health benefit plan or  
23 self-funded employer health benefit plan was the  
24 reason for declining enrollment;

25 (iii) has lost coverage under  
26 another health benefit plan or self-funded employer  
27 health benefit plan as a result of:

28 (a) the termination of  
29 employment;

30 (b) the reduction in the  
31 number of hours of employment;

32 (c) the termination of the  
33 other plan's coverage;

34 (d) the termination of  
35 contributions toward the premium made by the employer;  
36 or

37 (e) the death of a spouse  
38 or divorce; and

39 (iv) requests enrollment not  
40 later than the 31st day after the date on which  
41 coverage under the other health benefit plan or  
42 self-funded employer health benefit plan terminates;

43 (B) the individual is employed by an  
44 employer who offers multiple health benefit plans and  
45 the individual elects a different health benefit plan  
46 during an open enrollment period;

47 (C) a court has ordered coverage to  
48 be provided for a spouse under a covered employee's  
49 plan and request for enrollment is made not later than  
50 the 31st day after the date on which the court order is  
51 issued;

52 (D) a court has ordered coverage to  
53 be provided for a child under a covered employee's plan  
54 and the request for enrollment is made not later than  
55 the 31st day after the date on which the employer  
56 receives the court order; or

57 (E) the individual is a child of a  
58 covered employee who has lost coverage under Title XIX  
59 of the Social Security Act (42 U.S.C. Section 1396 et  
60 seq.), other than coverage consisting solely of  
61 benefits under Section 1928 of that Act (42 U.S.C.  
62 Section 1396s), or under Chapter 62, Health and Safety  
63 Code, and the request for enrollment is made not later  
64 than the 31st day after the date on which the child

1           loses coverage.

2                                   Revised Law

3           Sec. 1501.009. SCHOOL DISTRICT ELECTION.           (a)       An  
4 independent school district may elect to participate as a small  
5 employer without regard to the number of eligible employees in the  
6 district. An independent school district that makes the election  
7 is treated as a small employer under this chapter for all purposes.

8           (b) An independent school district that is participating in  
9 the uniform group coverage program established under Article 3.50-7  
10 may not participate in the small employer market under this section  
11 for health insurance coverage and may not renew a health insurance  
12 contract obtained in accordance with this section after the date on  
13 which the program of coverages provided under Article 3.50-7 is  
14 implemented. This subsection does not affect a contract for the  
15 provision of optional coverages not included in a health benefit  
16 plan under this chapter. (V.T.I.C. Art. 26.036.)

17                                   Source Law

18           Art. 26.036. (a) An independent school  
19 district may elect to participate in the small  
20 employer market without regard to the number of  
21 eligible employees of the independent school district.

22           (b) An independent school district that elects  
23 to participate in the small employer market under this  
24 article is treated as a small employer under this  
25 chapter for all purposes.

26           (c) An independent school district that is  
27 participating in the uniform group coverage program  
28 established under Article 3.50-7 of this code may not  
29 participate in the small employer market under this  
30 article for health insurance coverage and may not  
31 renew a health insurance contract obtained in  
32 accordance with this article after the date on which  
33 the program of coverages provided under Article 3.50-7  
34 of this code is implemented. This subsection does not  
35 affect a contract for the provision of optional  
36 coverages not included in a health benefits plan under  
37 this chapter.

38                                   Revised Law

39           Sec. 1501.010. GENERAL RULES. The commissioner shall  
40 adopt rules necessary to:

41                   (1) implement this chapter; and

42                   (2) meet the minimum requirements of federal law,  
43 including regulations. (V.T.I.C. Art. 26.04.)

Source Law

Art. 26.04. The commissioner shall adopt rules as necessary to implement this chapter and to meet the minimum requirements of federal law and regulations.

Revised Law

Sec. 1501.011. DETERMINATION OF EMPLOYER STATUS FOR CERTAIN EMPLOYERS. (a) For an employer that did not exist throughout the calendar year preceding the year in which the determination of whether the employer is a small employer is made, the determination is based on the average number of employees and eligible employees the employer reasonably expects to employ on business days in the calendar year in which the determination is made.

(b) For an employer that did not exist throughout the calendar year preceding the year in which the determination of whether the employer is a large employer is made, the determination is based on the average number of eligible employees the employer reasonably expects to employ on business days in the calendar year in which the determination is made. (V.T.I.C. Art. 26.06, Subsec. (b); Art. 26.81, Subsec. (b).)

## Source Law

[Art. 26.06]

(b) For an employer who was not in existence throughout the calendar year preceding the year in which the determination of whether the employer is a small employer is made, the determination is based on the average number of employees and eligible employees the employer reasonably expects to employ on business days in the calendar year in which the determination is made.

[Art. 26.81]

(b) For an employer who was not in existence throughout the calendar year preceding the year in which the determination of whether the employer is a large employer is made, the determination is based on the average number of eligible employees the employer reasonably expects to employ on business days in the calendar year in which the determination is made.

Revisor's Note  
(End of Subchapter)

V.T.I.C. Article 26.05 provides that a reference in V.T.I.C. Chapter 26 to a statute "applies to all reenactments, revisions, or amendments" of the statute. The revised law omits this provision as

unnecessary because it duplicates Section 311.027,  
Government Code (Code Construction Act), applicable to  
the revised law. The omitted law reads:

Art. 26.05. A reference in this  
chapter to a statutory provision applies to  
all reenactments, revisions, or amendments  
of that statutory provision.

[Sections 1501.012-1501.050 reserved for expansion]

#### SUBCHAPTER B. PURCHASING COOPERATIVES

##### Revised Law

Sec. 1501.051. DEFINITIONS. In this subchapter:

(1) "Board of directors" means the board of directors  
elected by a private purchasing cooperative.

(2) "Board of trustees" means the board of trustees of  
the Texas cooperative.

(3) "Cooperative" means a purchasing cooperative  
established under this subchapter.

(4) "Texas cooperative" means the Texas Health  
Benefits Purchasing Cooperative established under Section  
1501.052. (V.T.I.C. Art. 26.11.)

##### Source Law

Art. 26.11. In this subchapter:

(1) "Board of trustees" means the board of  
trustees of the Texas cooperative.

(2) "Board of directors" means the board  
of directors elected by a private purchasing  
cooperative.

(3) "Cooperative" means a purchasing  
cooperative established under this subchapter.

(4) "Texas cooperative" means the Texas  
Health Benefits Purchasing Cooperative, a nonprofit  
corporation, established under Article 26.13 of this  
code.

##### Revisor's Note

Subdivision (4), V.T.I.C. Article 26.11, refers  
to the Texas Health Benefits Purchasing Cooperative as  
a "nonprofit corporation." The revised law omits the  
quoted language because Subsection (a), V.T.I.C.  
Article 26.13, revised as Section 1501.052(a),  
provides that the cooperative is a nonprofit  
corporation. It is unnecessary to refer twice to the

1 cooperative's nonprofit status, and Section  
2 1501.052(a) is the more appropriate location for the  
3 reference because that section is a substantive  
4 provision.

5 Revised Law

6 Sec. 1501.052. TEXAS HEALTH BENEFITS PURCHASING  
7 COOPERATIVE; BOARD OF TRUSTEES. (a) The Texas Health Benefits  
8 Purchasing Cooperative is a nonprofit corporation established to  
9 make health care coverage available to small and large employers  
10 and their eligible employees and the eligible employees'  
11 dependents.

12 (b) The Texas cooperative is administered by a board of  
13 trustees of six members appointed by the governor with the advice  
14 and consent of the senate. Three members must represent employers,  
15 two members must represent employees, and one member must represent  
16 the public.

17 (c) Members of the board of trustees serve staggered  
18 six-year terms, with the terms of two members expiring February 1 of  
19 each odd-numbered year.

20 (d) A member of the board of trustees may not be compensated  
21 for serving on the board but is entitled to reimbursement for actual  
22 expenses incurred in performing functions as a member of the board  
23 as provided by the General Appropriations Act. (V.T.I.C.  
24 Art. 26.13, Subsecs. (a), (b), (c), (d).)

25 Source Law

26 Art. 26.13. (a) The Texas Health Benefits  
27 Purchasing Cooperative is a nonprofit corporation  
28 established to make health care coverage available to  
29 small and large employers and their eligible employees  
30 and eligible employees' dependents.

31 (b) The Texas cooperative is administered by a  
32 six-member board of trustees appointed by the governor  
33 with the advice and consent of the senate. Three  
34 members must represent employers, two members must  
35 represent employees, and one member must represent the  
36 public.

37 (c) The appointed members of the board of  
38 trustees serve staggered six-year terms, with the  
39 terms of two members expiring February 1 of each  
40 odd-numbered year.

41 (d) A member of the board of trustees may not be  
42 compensated for serving on the board of trustees but is

1 entitled to reimbursement for actual expenses incurred  
2 in performing functions as a member of the board of  
3 trustees as provided by the General Appropriations  
4 Act.

5 Revised Law

6 Sec. 1501.053. TEXAS HEALTH BENEFITS PURCHASING  
7 COOPERATIVE: EXECUTIVE DIRECTOR AND OTHER EMPLOYEES. (a) The  
8 board of trustees shall employ an executive director. The  
9 executive director may hire other employees of the Texas  
10 cooperative as necessary.

11 (b) Salaries for employees of the Texas cooperative and  
12 related costs may be paid from administrative fees collected from  
13 employers and participating health benefit plan issuers or other  
14 sources of funding arranged by the Texas cooperative. (V.T.I.C.  
15 Art. 26.13, Subsecs. (e), (g).)

16 Source Law

17 (e) The board of trustees shall employ an  
18 executive director. The executive director may hire  
19 other employees as necessary.

20 (g) Salaries for employees of the Texas  
21 cooperative and related costs may be paid from  
22 administrative fees collected from employers and  
23 participating carriers or other sources of funding  
24 arranged by the Texas cooperative.

25 Revised Law

26 Sec. 1501.054. REGIONAL SUBDIVISIONS OF TEXAS HEALTH  
27 BENEFITS PURCHASING COOPERATIVE. The board of trustees may:

28 (1) develop regional subdivisions of the Texas  
29 cooperative; and

30 (2) authorize each subdivision to separately exercise  
31 the powers and duties of a cooperative. (V.T.I.C. Art. 26.13,  
32 Subsec. (f).)

33 Source Law

34 (f) The board of trustees may develop regional  
35 subdivisions of the Texas cooperative and may  
36 authorize each subdivision to separately exercise the  
37 powers and duties of a cooperative.

38 Revised Law

39 Sec. 1501.055. APPLICABILITY OF PUBLIC INFORMATION LAW TO  
40 TEXAS HEALTH BENEFITS PURCHASING COOPERATIVE. The Texas

1 cooperative is subject to the public information law, Chapter 552,  
2 Government Code. (V.T.I.C. Art. 26.12, Subsec. (b).)

3 Source Law

4 (b) The Texas cooperative is subject to the open  
5 records law, Chapter 424, Acts of the 63rd  
6 Legislature, Regular Session, 1973 (Article 6252-17a,  
7 Vernon's Texas Civil Statutes).

8 Revisor's Note

9 Subsection (b), V.T.I.C. Article 26.12, refers to  
10 "the open records law, Chapter 424, Acts of the 63rd  
11 Legislature, Regular Session, 1973 (Article 6252-17a,  
12 Vernon's Texas Civil Statutes)." That statute was  
13 codified in 1993 as Chapter 552, Government Code.  
14 Section 1, Chapter 1035, Acts of the 74th Legislature,  
15 Regular Session, 1995, changed the heading of Chapter  
16 552, Government Code, from "Open Records" to "Public  
17 Information." The revised law is drafted accordingly.

18 Revised Law

19 Sec. 1501.056. PRIVATE PURCHASING COOPERATIVES. (a) Two  
20 or more small or large employers may form a private cooperative to  
21 purchase small or large employer health benefit plans. The  
22 cooperative must be organized as a nonprofit corporation and has  
23 the rights and duties provided by the Texas Non-Profit Corporation  
24 Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes).

25 (b) On receipt of a certificate of incorporation or  
26 certificate of authority from the secretary of state, the  
27 cooperative shall file written notice of the receipt of the  
28 certificate and a copy of the cooperative's organizational  
29 documents with the commissioner.

30 (c) Annually, the board of directors shall file with the  
31 commissioner a statement of all amounts collected and expenses  
32 incurred for each of the preceding three years. (V.T.I.C.  
33 Art. 26.14, Subsecs. (a), (b), (c).)

34 Source Law

35 Art. 26.14. (a) Two or more small or large  
36 employers may form a cooperative for the purchase of

1 small or large employer health benefit plans. A  
2 cooperative must be organized as a nonprofit  
3 corporation and has the rights and duties provided by  
4 the Texas Non-Profit Corporation Act (Article  
5 1396-1.01 et seq., Vernon's Texas Civil Statutes).

6 (b) On receipt of a certificate of incorporation  
7 or certificate of authority from the secretary of  
8 state, the cooperative shall file written notification  
9 of the receipt of the certificate and a copy of the  
10 cooperative's organizational documents with the  
11 commissioner.

12 (c) The board of directors shall file annually  
13 with the commissioner a statement of all amounts  
14 collected and expenses incurred for each of the  
15 preceding three years.

#### 16 Revised Law

17 Sec. 1501.057. IMMUNITY. (a) The Texas cooperative or a  
18 member of the board of trustees, the executive director, or an  
19 employee or agent of the Texas cooperative is not liable for:

20 (1) an act performed in good faith in the execution of  
21 duties in connection with the cooperative; or

22 (2) an independent action of a small employer health  
23 benefit plan issuer or a person who provides health care services  
24 under a health benefit plan.

25 (b) A private purchasing cooperative or a member of the  
26 board of directors, the executive director, or an employee or agent  
27 of the cooperative is not liable for:

28 (1) an act performed in good faith in the execution of  
29 duties in connection with the cooperative; or

30 (2) an independent action of a small or large employer  
31 health benefit plan issuer or a person who provides health care  
32 services under a health benefit plan. (V.T.I.C. Art. 26.13,  
33 Subsec. (h); Art. 26.14, Subsec. (d).)

#### 34 Source Law

35 [Art. 26.13]

36 (h) The Texas cooperative or a member of the  
37 board of trustees, the executive director, or an  
38 employee or agent of the Texas cooperative is not  
39 liable for:

40 (1) an act performed in good faith in the  
41 execution of duties in connection with the Texas  
42 cooperative; or

43 (2) an independent action of a small  
44 employer insurance carrier or a person who provides  
45 health care services under a health benefit plan.

46 [Art. 26.14]

47 (d) A purchasing cooperative or a member of the

1 board of directors, the executive director, or an  
2 employee or agent of a purchasing cooperative is not  
3 liable for:

4 (1) an act performed in good faith in the  
5 execution of duties in connection with the purchasing  
6 cooperative; or

7 (2) an independent action of a small or  
8 large employer insurance carrier or a person who  
9 provides health care services under a health benefit  
10 plan.

11 Revised Law

12 Sec. 1501.058. POWERS AND DUTIES OF COOPERATIVES. (a) A  
13 cooperative shall:

14 (1) arrange for small or large employer health benefit  
15 plan coverage for small or large employer groups that participate  
16 in the cooperative by contracting with small or large employer  
17 health benefit plan issuers that meet the requirements established  
18 by Section 1501.061;

19 (2) collect premiums to cover the cost of:

20 (A) small or large employer health benefit plan  
21 coverage purchased through the cooperative; and

22 (B) the cooperative's administrative expenses;

23 (3) establish administrative and accounting  
24 procedures for the operation of the cooperative;

25 (4) establish procedures under which an applicant for  
26 or participant in coverage issued through the cooperative may have  
27 a grievance reviewed by an impartial person;

28 (5) contract with small or large employer health  
29 benefit plan issuers to provide services to small or large  
30 employers covered through the cooperative; and

31 (6) develop and implement a plan to maintain public  
32 awareness of the cooperative and publicize the eligibility  
33 requirements for, and the procedures for enrollment in, coverage  
34 through the cooperative.

35 (b) A cooperative may:

36 (1) contract with agents to market coverage issued  
37 through the cooperative;

38 (2) contract with a small or large employer health  
39 benefit plan issuer or third-party administrator to provide

1 administrative services to the cooperative;

2 (3) negotiate the premiums paid by its members; and

3 (4) offer other ancillary products and services to its  
4 members that are customarily offered in conjunction with health  
5 benefit plans.

6 (c) A cooperative shall comply with:

7 (1) federal laws applicable to cooperatives and health  
8 benefit plans issued through cooperatives, to the extent required  
9 by state law or rules adopted by the commissioner; and

10 (2) state laws applicable to cooperatives and health  
11 benefit plans issued through cooperatives. (V.T.I.C. Art. 26.15,  
12 Subsecs. (a), (d).)

13 Source Law

14 Art. 26.15. (a) A cooperative:

15 (1) shall arrange for small or large  
16 employer health benefit plan coverage for small or  
17 large employer groups who participate in the  
18 cooperative by contracting with small or large  
19 employer carriers who meet the criteria established by  
20 Subsection (b) of this article;

21 (2) shall collect premiums to cover the  
22 cost of:

23 (A) small or large employer health  
24 benefit plan coverage purchased through the  
25 cooperative; and

26 (B) the cooperative's administrative  
27 expenses;

28 (3) may contract with agents to market  
29 coverage issued through the cooperative;

30 (4) shall establish administrative and  
31 accounting procedures for the operation of the  
32 cooperative;

33 (5) shall establish procedures under which  
34 an applicant for or participant in coverage issued  
35 through the cooperative may have a grievance reviewed  
36 by an impartial person;

37 (6) may contract with a small or large  
38 employer carrier or third-party administrator to  
39 provide administrative services to the cooperative;

40 (7) shall contract with small or large  
41 employer carriers for the provision of services to  
42 small or large employers covered through the  
43 cooperative;

44 (8) shall develop and implement a plan to  
45 maintain public awareness of the cooperative and  
46 publicize the eligibility requirements for, and the  
47 procedures for enrollment in coverage through, the  
48 cooperative;

49 (9) may negotiate the premiums paid by its  
50 members; and

51 (10) may offer such other ancillary  
52 products and services to its members as are  
53 customarily offered in conjunction with health benefit  
54 plans.

1 (d) A cooperative shall comply with federal laws  
2 applicable to cooperatives and health benefit plans  
3 issued through cooperatives, to the extent required by  
4 state law or rules adopted by the commissioner of  
5 insurance. A cooperative shall comply with state laws  
6 applicable to cooperatives and health benefit plans  
7 issued through cooperatives.

8 Revisor's Note

9 Subsection (d), V.T.I.C. Article 26.15, refers to  
10 the "commissioner of insurance." Chapter 31,  
11 Insurance Code, defines "commissioner" for purposes of  
12 this code and the other insurance laws of this state to  
13 mean the commissioner of insurance. The revised law is  
14 drafted accordingly.

15 Revised Law

16 Sec. 1501.059. SELF-INSURED OR SELF-FUNDED PLAN  
17 PROHIBITED. A cooperative may not self-insure or self-fund any  
18 health benefit plan or portion of a plan. (V.T.I.C. Art. 26.15,  
19 Subsec. (c).)

20 Source Law

21 (c) A cooperative may not self-insure or  
22 self-fund any health benefit plan or portion of a plan.

23 Revised Law

24 Sec. 1501.060. SCOPE OF GROUP COVERAGE. Subchapter B,  
25 Chapter 1251, does not limit the type of group that may be covered  
26 by a group health benefit plan issued through a cooperative.  
27 (V.T.I.C. Art. 26.12, Subsec. (a).)

28 Source Law

29 Art. 26.12. (a) Section 1(a), Article 3.51-6,  
30 of this code, does not limit the type of group that may  
31 be covered by a group health benefit plan issued  
32 through a cooperative.

33 Revised Law

34 Sec. 1501.061. REQUIREMENTS APPLICABLE TO HEALTH BENEFIT  
35 PLAN ISSUERS WITH WHICH COOPERATIVE MAY CONTRACT. A cooperative  
36 may contract only with a small or large employer health benefit plan  
37 issuer that desires to offer coverage through the cooperative and  
38 that demonstrates that the issuer:

39 (1) is in good standing with the department;



1 [Texas Department of Insurance]." The revised law  
2 omits the references to "health carrier" and "health  
3 maintenance organization" as unnecessary. The  
4 reference to "health maintenance organization" is  
5 unnecessary because Subdivision (12), V.T.I.C.  
6 Article 26.02, revised as Section 1501.002(6), defines  
7 "health benefit plan issuer" to include a health  
8 maintenance organization. The reference to "health  
9 carrier" is unnecessary because Subdivision (16),  
10 V.T.I.C. Article 26.02, revised as Section  
11 1501.002(10), defines "large employer health benefit  
12 plan issuer" and Subdivision (30), V.T.I.C. Article  
13 26.02, as amended by Chapter 608, Acts of the 77th  
14 Legislature, Regular Session, 2001, and Subdivision  
15 (31), V.T.I.C. Article 26.02, as amended by Chapter  
16 823, Acts of the 77th Legislature, Regular Session,  
17 2001, revised as Section 1501.002(16), define "small  
18 employer health benefit plan issuer" to mean a health  
19 benefit plan issuer to the extent it offers health  
20 benefit plans subject to this chapter. The revised law  
21 omits the reference to "licensed" as unnecessary  
22 because a health benefit plan issuer must be licensed  
23 to be "in good standing" with the Texas Department of  
24 Insurance.

25 Revised Law

26 Sec. 1501.062. COOPERATIVE NOT INSURER; AGENTS AND  
27 ADMINISTRATORS. (a) A cooperative is not an insurer and the  
28 employees of the cooperative are not required to be licensed under  
29 Title 13.

30 (b) An agent or third-party administrator used and  
31 compensated by a cooperative must be licensed as required by Title  
32 13.

33 (c) An agent used and compensated by a cooperative may  
34 market the products and services sponsored by the cooperative

1 without being appointed by each small employer health benefit plan  
2 issuer participating in the cooperative. The agent may not market  
3 any other product or service of a participating issuer that is not  
4 sponsored by the cooperative unless the agent has been appointed by  
5 that issuer. (V.T.I.C. Art. 26.16, Subsecs. (a), (c), (d).)

6 Source Law

7 Art. 26.16. (a) A cooperative is not an  
8 insurer and the employees of the cooperative are not  
9 required to be licensed under Section 15 or 15A, Texas  
10 Health Maintenance Organization Act (Article 20A.15 or  
11 20A.15A, Vernon's Texas Insurance Code), or Subchapter  
12 A, Chapter 21, of this code.

13 (c) An agent or third-party administrator used  
14 and compensated by the cooperative must be licensed as  
15 required by Section 15 or 15A, Texas Health  
16 Maintenance Organization Act (Article 20A.15 or  
17 20A.15A, Vernon's Texas Insurance Code), or Subchapter  
18 A, Chapter 21, of this code.

19 (d) A licensed agent used and compensated by the  
20 cooperative need not be appointed by each small  
21 employer carrier participating in the cooperative in  
22 order to market the products and services sponsored by  
23 the cooperative. However, a licensed agent may not  
24 market any other non-sponsored product or service of a  
25 participating small employer carrier without first  
26 being appointed by the small employer carrier.

27 Revisor's Note

28 (1) Subsection (a), V.T.I.C. Article 26.16,  
29 provides in part that employees of a purchasing  
30 cooperative "are not required to be licensed under  
31 Section 15 or 15A, Texas Health Maintenance  
32 Organization Act (Article 20A.15 or 20A.15A, Vernon's  
33 Texas Insurance Code), or Subchapter A, Chapter 21, of  
34 this code." Subsection (c), V.T.I.C. Article 26.16,  
35 provides that an agent or third-party administrator  
36 used and compensated by a purchasing cooperative "must  
37 be licensed as required by Section 15 or 15A, Texas  
38 Health Maintenance Organization Act (Article 20A.15 or  
39 20A.15A, Vernon's Texas Insurance Code), or Subchapter  
40 A, Chapter 21, of this code." The revised law omits  
41 the references to Articles 20A.15 and 20A.15A for the  
42 reason stated in Revisor's Note (1) to Section  
43 1501.002.

1           (2) Subsection (d), V.T.I.C. Article 26.16,  
2       refers to a "licensed agent." The revised law omits  
3       the reference to "licensed" because the concept is  
4       included in the definition of "agent" under  
5       Subdivision (2), V.T.I.C. Article 26.02, revised as  
6       Section 1501.002(1).

7                               Revised Law

8       Sec. 1501.063. COOPERATIVE AS EMPLOYER. A cooperative is  
9       considered an employer solely for the purposes of benefit elections  
10      under this code. (V.T.I.C. Art. 26.16, Subsec. (b).)

11                              Source Law

12           (b) A cooperative is considered an employer  
13      solely for the purposes of benefit elections under the  
14      code.

15                              Revised Law

16      Sec. 1501.064. CERTAIN USE OF APPROPRIATED MONEY  
17      PROHIBITED. The Texas cooperative may not use money appropriated  
18      by the state to pay or otherwise subsidize any portion of the  
19      premium for a small employer covered through the cooperative.  
20      (V.T.I.C. Art. 26.13, Subsec. (i).)

21                              Source Law

22           (i) The Texas cooperative may not use money  
23      appropriated by the state to pay or otherwise  
24      subsidize any portion of the premium for a small  
25      employer insured through the cooperative.

26           [Sections 1501.065-1501.100 reserved for expansion]

27                              SUBCHAPTER C. PROVISION OF COVERAGE

28                              Revised Law

29      Sec. 1501.101. GEOGRAPHIC SERVICE AREAS. (a) A small or  
30      large employer health benefit plan issuer must file each of the  
31      issuer's geographic service areas with the commissioner. The  
32      commissioner may disapprove the use of a geographic service area by  
33      a small or large employer health benefit plan issuer.

34           (b) A small employer health benefit plan issuer that refuses  
35      to issue a small employer health benefit plan in a geographic  
36      service area may not offer a health benefit plan to a small employer

1 in the applicable service area before the fifth anniversary of the  
2 date of the refusal.

3 (c) A small or large employer health benefit plan issuer is  
4 not required to offer or issue a small or large employer health  
5 benefit plan to:

6 (1) a small or large employer that is not located  
7 within a geographic service area of the issuer;

8 (2) an employee of a small or large employer who  
9 neither resides nor works in the geographic service area of the  
10 issuer; or

11 (3) a small or large employer located within a  
12 geographic service area of the issuer with respect to which area the  
13 issuer demonstrates to the commissioner's satisfaction that the  
14 issuer:

15 (A) reasonably anticipates that it will not have  
16 the capacity to deliver services adequately because of obligations  
17 to existing covered individuals; and

18 (B) is acting uniformly without regard to the  
19 claims experience of the employer or any health status related  
20 factor of employees, employees' dependents, or new employees or  
21 dependents who may become eligible for the coverage.

22 (d) A small or large employer health benefit plan issuer  
23 that is unable to offer coverage in a geographic service area in  
24 accordance with a determination made by the commissioner under  
25 Subsection (c)(3) may not offer a small or large employer benefit  
26 plan, as applicable, in that service area before the 180th day after  
27 the later of:

28 (1) the date the issuer refuses to offer coverage; or

29 (2) the date the issuer demonstrates to the  
30 satisfaction of the commissioner that it has regained the capacity  
31 to deliver services to small or large employers in the geographic  
32 service area.

33 (e) If the commissioner determines that requiring the  
34 acceptance of small or large employers under this chapter would

1 place a small or large employer health benefit plan issuer in a  
2 financially impaired condition and that the issuer is acting  
3 uniformly without regard to the claims experience of the small or  
4 large employer or any health status related factors of eligible  
5 employees, eligible employees' dependents, or new employees or  
6 dependents who may become eligible for the coverage, the issuer may  
7 not offer coverage to small or large employers until the later of:

8 (1) the 180th day after the date the commissioner  
9 makes the determination; or

10 (2) the date the commissioner determines that  
11 accepting small or large employers would not place the issuer in a  
12 financially impaired condition. (V.T.I.C. Arts. 26.22, 26.85.)

13 Source Law

14 Art. 26.22. (a) A small employer carrier is  
15 not required to offer or issue the small employer  
16 health benefit plans:

17 (1) to a small employer that is not located  
18 within a geographic service area of the small employer  
19 carrier;

20 (2) to an employee of a small employer who  
21 neither resides nor works in the geographic service  
22 area of the small employer carrier; or

23 (3) to a small employer located within a  
24 geographic service area with respect to which the  
25 small employer carrier demonstrates to the  
26 satisfaction of the commissioner that:

27 (A) the small employer carrier  
28 reasonably anticipates that it will not have the  
29 capacity to deliver services adequately because of  
30 obligations to existing covered individuals; and

31 (B) the small employer carrier is  
32 acting uniformly without regard to claims experience  
33 of the employer or any health status related factor of  
34 employees or dependents or new employees or dependents  
35 who may become eligible for the coverage.

36 (b) A small employer carrier that refuses to  
37 issue a small employer health benefit plan in a  
38 geographic service area may not offer a health benefit  
39 plan to a small employer in the affected service area  
40 before the fifth anniversary of the date of the  
41 refusal.

42 (c) A small employer carrier must file each of  
43 its geographic service areas with the commissioner.  
44 The commissioner may disapprove the use of a  
45 geographic service area by a small employer carrier.

46 (d) A small employer carrier that is unable to  
47 offer coverage in a geographic service area in  
48 accordance with a determination made by the  
49 commissioner under Subsection (a)(3) of this article  
50 may not offer a small employer benefit plan in the  
51 applicable geographic service area before the 180th  
52 day after the later of:

53 (1) the date of the refusal; or

54 (2) the date the carrier demonstrates to

1 the satisfaction of the commissioner that it has  
2 regained the capacity to deliver services to small  
3 employers in the geographic service area.

4 (e) If the commissioner determines that  
5 requiring the acceptance of small employers under this  
6 subchapter would place a small employer carrier in a  
7 financially impaired condition and that the small  
8 employer carrier is acting uniformly without regard to  
9 the claims experience of the small employer or any  
10 health status related factors of eligible employees or  
11 dependents or new employees or dependents who may  
12 become eligible for the coverage, the small employer  
13 carrier shall not offer coverage to small employers  
14 until the later of:

15 (1) the 180th day after the date the  
16 commissioner makes the determination; or

17 (2) the date the commissioner determines  
18 that accepting small employers would not place the  
19 small employer carrier in a financially impaired  
20 condition.

21 Art. 26.85. (a) A large employer carrier is  
22 not required to offer or issue the large employer  
23 health benefit plans to:

24 (1) a large employer that is not located  
25 within a geographic service area of the large employer  
26 carrier;

27 (2) an employee of a large employer who  
28 neither resides nor works in the geographic service  
29 area of the large employer carrier; or

30 (3) a large employer located within a  
31 geographic service area with respect to which the  
32 large employer carrier demonstrates to the  
33 satisfaction of the commissioner that the large  
34 employer carrier:

35 (A) reasonably anticipates that it  
36 will not have the capacity to deliver services  
37 adequately because of obligations to existing covered  
38 individuals; and

39 (B) is acting uniformly without  
40 regard to the claims experience of the large employer  
41 or any health status related factor of employees or  
42 dependents or new employees or dependents who may  
43 become eligible for the coverage.

44 (b) A large employer carrier that is unable to  
45 offer coverage in a geographic service area in  
46 accordance with a determination made by the  
47 commissioner under Subsection (a)(3) of this article  
48 may not offer large employer benefit plans in the  
49 applicable service area before the 180th day after the  
50 later of:

51 (1) the date of the refusal; or

52 (2) the date the carrier demonstrates to  
53 the satisfaction of the commissioner that it has  
54 regained the capacity to deliver services to large  
55 employers in the geographic service area.

56 (c) If the commissioner determines that  
57 requiring the acceptance of large employers under this  
58 subchapter would place a large employer carrier in a  
59 financially impaired condition and that the large  
60 employer carrier is acting uniformly without regard to  
61 claims experience of the large employer or any health  
62 status related factors of employees or dependents or  
63 new employees or dependents who may become eligible  
64 for the coverage, the large employer carrier may not  
65 offer coverage to large employers until the later of:

66 (1) the 180th day after the date the  
67 commissioner makes the determination; or

1                   (2) the date the commissioner determines  
2 that accepting large employers would not place the  
3 large employer carrier in a financially impaired  
4 condition.

5                   (d) A large employer carrier must file each of  
6 its geographic service areas with the commissioner.  
7 The commissioner may disapprove the use of a  
8 geographic service area by a large employer carrier.

9                   Revisor's Note

10                   Subsection (e), V.T.I.C. Article 26.22, provides  
11 that a small employer carrier is not required to offer  
12 coverage to small employers if the commissioner of  
13 insurance determines that accepting small employers  
14 would place the carrier in a financially impaired  
15 condition and that "the small employer carrier is  
16 acting uniformly without regard to the claims  
17 experience of the small employer or any health status  
18 related factors of eligible employees or dependents or  
19 new employees or dependents who may become eligible  
20 for the coverage." Subsection (c), V.T.I.C. Article  
21 26.85, provides that a large employer carrier is not  
22 required to offer coverage to large employers if the  
23 commissioner of insurance determines that accepting  
24 large employers would place the carrier in a  
25 financially impaired condition and that "the large  
26 employer carrier is acting uniformly without regard to  
27 claims experience of the large employer or any health  
28 status related factors of employees or dependents or  
29 new employees or dependents who may become eligible  
30 for the coverage." The revised law refers to "health  
31 status related factors of eligible employees, eligible  
32 employees' dependents, or new employees or dependents  
33 who may become eligible for coverage" because a small  
34 or large health benefit plan issuer's consideration of  
35 health status related factors is relevant only in  
36 connection with employees and dependents who are  
37 eligible for coverage.

Revised Law

Sec. 1501.102. PREEXISTING CONDITION PROVISION. (a) In this section, "creditable coverage" has the meaning assigned by Section 1205.004 and includes coverage provided under:

(1) a political subdivision health benefits risk pool;

and

(2) a short-term limited duration coverage plan.

(b) A preexisting condition provision in a small or large employer health benefit plan may apply only to coverage for a disease or condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months before the earlier of:

(1) the effective date of coverage; or

(2) the first day of the waiting period.

(c) A preexisting condition provision in a small or large employer health benefit plan may not apply to expenses incurred on or after the first anniversary of the initial effective date of coverage of the enrollee, including a late enrollee.

(d) A preexisting condition provision in a small or large employer health benefit plan may not apply to an individual who was continuously covered for an aggregate period of 12 months under creditable coverage that was in effect until a date not more than 63 days before the effective date of coverage under the plan, excluding any waiting period.

(e) In determining whether a preexisting condition provision applies to an individual covered by a small or large employer health benefit plan, the plan issuer shall credit the time the individual was covered under previous creditable coverage if the previous coverage was in effect at any time during the 12 months preceding the effective date of coverage under the plan. If the previous coverage was issued under a health benefit plan, any waiting period that applied before that coverage became effective must also be credited against the preexisting condition provision period. (V.T.I.C. Art. 26.02, Subdiv. (7); Art. 26.035;

Art. 26.49, Subsecs. (a), (b), (e), (f); Art. 26.90, Subsecs. (a), (b), (e), (f).)

Source Law

Art. 26.02. In this chapter:

(7) "Creditable coverage" means coverage described by Article 26.035 of this code.

Art. 26.035. (a) An individual's coverage is creditable for purposes of this chapter if the coverage is provided under:

(1) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(2) a group health benefit plan provided by a health insurance carrier or health maintenance organization;

(3) an individual health insurance policy or evidence of coverage;

(4) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);

(5) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s);

(6) Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.);

(7) a medical care program of the Indian Health Service or of a tribal organization;

(8) a state or political subdivision health benefits risk pool;

(9) a health plan offered under Chapter 89, Title 5, United States Code (5 U.S.C. Section 8901 et seq.);

(10) a public health plan as defined by federal regulations;

(11) a health benefit plan under Section 5(e), Peace Corps Act (22 U.S.C. Section 2504(e)); or

(12) short term limited duration coverage.

(b) Creditable coverage does not include:

(1) accident-only or disability income insurance, or a combination of accident-only and disability income insurance;

(2) coverage issued as a supplement to liability insurance;

(3) liability insurance, including general liability insurance and automobile liability insurance;

(4) workers' compensation or similar insurance;

(5) automobile medical payment insurance;

(6) credit-only insurance;

(7) coverage for on-site medical clinics;

(8) other coverage that is:

(A) similar to the coverage described by this subsection under which benefits for medical care are secondary or incidental to other insurance benefits; and

(B) specified in federal regulations;

(9) coverage that provides limited-scope dental or vision benefits;

1 (10) long-term care coverage or benefits,  
2 nursing home care coverage or benefits, home health  
3 care coverage or benefits, community-based care  
4 coverage or benefits, or any combination of those  
5 coverages or benefits;

6 (11) coverage that provides other limited  
7 benefits specified by federal regulations;

8 (12) coverage for a specified disease or  
9 illness;

10 (13) hospital indemnity or other fixed  
11 indemnity insurance; or

12 (14) Medicare supplemental health  
13 insurance as defined under Section 1882(g)(1), Social  
14 Security Act (42 U.S.C. Section 1395ss), coverage  
15 supplemental to the coverage provided under Chapter  
16 55, Title 10, United States Code (10 U.S.C. Section  
17 1071 et seq.), and similar supplemental coverage  
18 provided under a group plan.

19 Art. 26.49. (a) A preexisting condition  
20 provision in a small employer health benefit plan may  
21 not apply to expenses incurred on or after the  
22 expiration of the 12 months following the initial  
23 effective date of coverage of the enrollee or late  
24 enrollee.

25 (b) A preexisting condition provision in a small  
26 employer health benefit plan may not apply to coverage  
27 for a disease or condition other than a disease or  
28 condition for which medical advice, diagnosis, care,  
29 or treatment was recommended or received during the  
30 six months before the earlier of:

31 (1) the effective date of coverage; or

32 (2) the first day of the waiting period.

33 (e) A preexisting condition provision in a small  
34 employer health benefit plan may not apply to an  
35 individual who was continuously covered for an  
36 aggregate period of 12 months under creditable  
37 coverage that was in effect up to a date not more than  
38 63 days before the effective date of coverage under the  
39 small employer health benefit plan, excluding any  
40 waiting period.

41 (f) In determining whether a preexisting  
42 condition provision applies to an individual covered  
43 by a small employer health benefit plan, the small  
44 employer carrier shall credit the time the individual  
45 was covered under creditable coverage if the previous  
46 coverage was in effect at any time during the 12 months  
47 preceding the effective date of coverage under a small  
48 employer health benefit plan. If the previous  
49 coverage was issued under a health benefit plan, any  
50 waiting period that applied before that coverage  
51 became effective also shall be credited against the  
52 preexisting condition provision period.

53 Art. 26.90. (a) A preexisting condition  
54 provision in a large employer health benefit plan may  
55 not apply to an expense incurred on or after the  
56 expiration of the 12 months following the initial  
57 effective date of coverage of the enrollee or late  
58 enrollee.

59 (b) A preexisting condition provision in a large  
60 employer health benefit plan may not apply to coverage  
61 for a disease or condition other than a disease or  
62 condition for which medical advice, diagnosis, care,  
63 or treatment was recommended or received during the  
64 six months before the earlier of:

65 (1) the effective date of coverage; or

1 (2) the first day of the waiting period.

2 (e) A preexisting condition provision in a large  
3 employer health benefit plan shall not apply to an  
4 individual who was continuously covered for an  
5 aggregate period of 12 months under creditable  
6 coverage that was in effect up to a date not more than  
7 63 days before the effective date of coverage under the  
8 large employer health benefit plan, excluding any  
9 waiting period.

10 (f) In determining whether a preexisting  
11 condition provision applies to an individual covered  
12 by a large employer health benefit plan, the large  
13 employer carrier shall credit the time the individual  
14 was covered under creditable coverage if the previous  
15 coverage was in effect at any time during the 12 months  
16 preceding the effective date of coverage under a large  
17 employer health benefit plan. If the previous  
18 coverage was issued under a health benefit plan, any  
19 waiting period shall also be credited to the  
20 preexisting condition provision period.

21 Revisor's Note

22 Subdivision (7), V.T.I.C. Article 26.02, defines  
23 "creditable coverage" to mean coverage "described by  
24 Article 26.035 of this code." That definition of  
25 "creditable coverage" was adopted by Chapter 955, Acts  
26 of the 75th Legislature, Regular Session, 1997. A  
27 substantially identical definition appeared three  
28 times in Chapter 955, in sections amending Chapter 26,  
29 Insurance Code, adding Article 21.52G, Insurance Code,  
30 and adding Article 3.95-1.5, Insurance Code. The  
31 intent of the legislature in enacting Chapter 955 was  
32 to implement federal requirements on health insurance  
33 portability and availability; the use of the same  
34 definition in three different articles was to ensure  
35 compliance with the federal requirements. The  
36 definition contained in Article 21.52G, Insurance  
37 Code, is revised in this code in Section 1205.004. The  
38 only substantive differences between the two  
39 provisions are that Subsection (a)(8), Article 26.035,  
40 explicitly references coverage provided under a  
41 political subdivision health benefits risk pool and  
42 Subsection (a)(12), Article 26.035, explicitly  
43 references coverage provided under short-term limited

1 duration coverage, neither of which is explicitly  
2 referenced in Section 3, Article 21.52G. Therefore,  
3 to avoid unnecessary duplication, the revised law  
4 substitutes a cross-reference to Section 1205.004 for  
5 the substance of Subdivision (7), Article 26.02, but  
6 continues explicit references to a political  
7 subdivision health benefits risk pool and to  
8 short-term limited duration coverage.

9 Revised Law

10 Sec. 1501.103. TREATMENT OF CERTAIN CONDITIONS AS  
11 PREEXISTING PROHIBITED. (a) A small or large employer health  
12 benefit plan issuer may not treat genetic information as a  
13 preexisting condition described by Section 1501.102(b) in the  
14 absence of a diagnosis of the condition related to the information.

15 (b) A small or large employer health benefit plan issuer may  
16 not treat pregnancy as a preexisting condition described by Section  
17 1501.102(b). (V.T.I.C. Art. 26.49, Subsecs. (c), (d); Art. 26.90,  
18 Subsecs. (c), (d).)

19 Source Law

20 [Art. 26.49]

21 (c) A small employer carrier shall not treat  
22 genetic information as a preexisting condition  
23 described by Subsection (b) of this article in the  
24 absence of a diagnosis of the condition related to the  
25 information.

26 (d) A small employer carrier shall not treat a  
27 pregnancy as a preexisting condition described by  
28 Subsection (b) of this article.

29 [Art. 26.90]

30 (c) A large employer carrier shall not treat  
31 genetic information as a preexisting condition  
32 described by Subsection (b) of this article in the  
33 absence of a diagnosis of the condition related to the  
34 information.

35 (d) A large employer carrier shall not treat a  
36 pregnancy as a preexisting condition described by  
37 Subsection (b) of this article.

38 Revised Law

39 Sec. 1501.104. AFFILIATION PERIOD. (a) In this section,  
40 "affiliation period" means a period that, under a small or large  
41 employer health benefit plan offered by a health maintenance  
42 organization, must expire before the coverage becomes effective.

(b) A health maintenance organization may impose an affiliation period if the period is applied uniformly without regard to any health status related factor. The affiliation period may not exceed:

(1) two months for an enrollee, other than a late enrollee; or

(2) 90 days for a late enrollee.

(c) An affiliation period under a small or large employer health benefit plan must run concurrently with any applicable waiting period under the plan. A health maintenance organization must credit an affiliation period against any preexisting condition provision period.

(d) During an affiliation period, a health maintenance organization:

(1) is not required to provide health care services or benefits to the participant or beneficiary; and

(2) may not charge a premium to the participant or beneficiary.

(e) A health maintenance organization may use an alternative method approved by the commissioner to address adverse selection. (V.T.I.C. Art. 26.02, Subdiv. (1); Art. 26.49, Subsec. (g); Art. 26.90, Subsec. (g).)

#### Source Law

Art. 26.02. In this chapter:

(1) "Affiliation period" means a period that, under the terms of the coverage offered by a health maintenance organization, must expire before the coverage becomes effective. During an affiliation period:

(A) a health maintenance organization is not required to provide health care services or benefits to the participant or beneficiary; and

(B) a premium may not be charged to the participant or beneficiary.

[Art. 26.49]

(g) A health maintenance organization may impose an affiliation period if the period is applied uniformly without regard to any health status related factor. The affiliation period shall not exceed two months for an enrollee, other than a late enrollee, and shall not exceed 90 days for a late enrollee. An affiliation period under a plan shall run concurrently

1 with any applicable waiting period under the plan. The  
2 health maintenance organization must credit an  
3 affiliation period to any preexisting condition  
4 provision period. A health maintenance organization  
5 may use an alternative method approved by the  
6 commissioner to address adverse selection.

7 [Art. 26.90]

8 (g) A health maintenance organization may  
9 impose an affiliation period if the period is applied  
10 uniformly without regard to any health status related  
11 factor. The affiliation period shall not exceed two  
12 months for an enrollee, other than a late enrollee, and  
13 shall not exceed 90 days for a late enrollee. An  
14 affiliation period under a plan shall run concurrently  
15 with any applicable waiting period under the plan. The  
16 health maintenance organization must credit an  
17 affiliation period to any preexisting condition  
18 provision period. A health maintenance organization  
19 may use an alternative method approved by the  
20 commissioner to address adverse selection.

21 Revised Law

22 Sec. 1501.105. WAITING PERIOD PERMITTED. Sections  
23 1501.102-1501.104 do not preclude application of a waiting period  
24 that applies to all new enrollees under a small or large employer  
25 health benefit plan. (V.T.I.C. Art. 26.49, Subsec. (h);  
26 Art. 26.90, Subsec. (h).)

27 Source Law

28 [Art. 26.49]

29 (h) This article does not preclude application  
30 of any waiting period applicable to all new enrollees  
31 under the health benefit plan.

32 [Art. 26.90]

33 (h) This article does not preclude application  
34 of any waiting period applicable to all new enrollees  
35 under the health benefit plan.

36 Revised Law

37 Sec. 1501.106. CERTAIN LIMITATIONS OR EXCLUSIONS OF  
38 COVERAGE PROHIBITED. (a) A small or large employer health  
39 benefit plan may not limit or exclude, by use of a rider or  
40 amendment applicable to a specific individual, coverage by type of  
41 illness, treatment, medical condition, or accident.

42 (b) This section does not preclude a small or large employer  
43 health benefit plan from limiting or excluding coverage for a  
44 preexisting condition in accordance with Section 1501.102.  
45 (V.T.I.C. Art. 26.21, Subsec. (m); Art. 26.83, Subsec. (m).)

## Source Law

[Art. 26.21]

(m) A small employer health benefit plan issued by a small employer carrier may not limit or exclude, by use of a rider or amendment applicable to a specific individual, coverage by type of illness, treatment, medical condition, or accident, except for preexisting conditions or diseases as permitted under Article 26.49 of this code.

[Art. 26.83]

(m) A large employer health benefit plan may not, by use of a rider or amendment applicable to a specific individual, limit or exclude coverage by type of illness, treatment, medical condition, or accident, except for a preexisting condition permitted under Article 26.90 of this code.

## Revisor's Note

Subsection (m), V.T.I.C. Article 26.21, refers to "preexisting conditions or diseases." The reference to "diseases" is omitted from the revised law because the concept is included within the definition of "preexisting condition provision" under Subdivision (24), V.T.I.C. Article 26.02, revised as Section 1501.002(12).

## Revised Law

Sec. 1501.107. DISCOUNTS, REBATES, AND REDUCTIONS. (a) A small or large employer health benefit plan issuer may establish premium discounts, rebates, or a reduction in otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(b) A discount, rebate, or reduction established under this section does not violate Section 541.056(a). (V.T.I.C. Art. 26.33, Subsec. (e); Art. 26.89, Subsec. (b).)

## Source Law

[Art. 26.33]

(e) A small employer carrier may establish premium discounts, rebates, or a reduction in otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention. A discount, rebate, or reduction established under this subsection does not violate Section 4(8), Article 21.21, of this code.

[Art. 26.89]

(b) A large employer carrier may establish premium discounts, rebates, or a reduction in otherwise applicable copayments or deductibles in

1 return for adherence to programs of health promotion  
2 and disease prevention. A discount, rebate, or  
3 reduction established under this subsection does not  
4 violate Section 4(8), Article 21.21, of this code.

5 Revised Law

6 Sec. 1501.108. RENEWABILITY OF COVERAGE; CANCELLATION. (a)  
7 Except as provided by Section 1501.109, a small or large employer  
8 health benefit plan issuer shall renew the small or large employer  
9 health benefit plan for any covered small or large employer, as  
10 applicable, at the employer's option, unless:

11 (1) a premium has not been paid as required by the  
12 terms of the plan;

13 (2) the employer has committed fraud or has  
14 intentionally misrepresented a material fact;

15 (3) the employer has not complied with the terms of the  
16 plan;

17 (4) no enrollee in the plan resides or works in the  
18 geographic service area of the small or large employer health  
19 benefit plan issuer or in the area for which the issuer is  
20 authorized to do business; or

21 (5) membership of the employer in an association  
22 terminates, but only if coverage is terminated uniformly without  
23 regard to a health status related factor of a covered individual.

24 (b) A small or large employer health benefit plan issuer may  
25 refuse to renew the coverage of a covered employee or dependent for  
26 fraud or intentional misrepresentation of a material fact by that  
27 individual.

28 (c) A small or large employer health benefit plan issuer may  
29 not cancel a small or large employer health benefit plan except for  
30 a reason specified for refusal to renew under Subsection (a). A  
31 small or large employer health benefit plan issuer may not cancel  
32 the coverage of a covered employee or dependent except for a reason  
33 specified for refusal to renew under Subsection (b). (V.T.I.C.  
34 Arts. 26.23, 26.86.)

35 Source Law

36 Art. 26.23. (a) Except as provided by Article

1 26.24 of this code, a small employer carrier shall  
2 renew the small employer health benefit plan for any  
3 covered small employer, at the option of the small  
4 employer, unless:

5 (1) a premium has not been paid as required  
6 by the terms of the plan;

7 (2) the small employer has committed fraud  
8 or intentional misrepresentation of a material fact;

9 (3) the small employer has not complied  
10 with the terms of the health benefit plan;

11 (4) no enrollee in connection with the  
12 plan resides or works in the service area of the small  
13 employer carrier or in the area for which the small  
14 employer carrier is authorized to do business; or

15 (5) membership of an employer in an  
16 association terminates, but only if coverage is  
17 terminated uniformly without regard to a health status  
18 related factor of a covered individual.

19 (b) A small employer carrier may refuse to renew  
20 the coverage of a covered employee or dependent for  
21 fraud or intentional misrepresentation of a material  
22 fact by that individual.

23 (c) A small employer carrier may not cancel a  
24 small employer health benefit plan except for the  
25 reasons specified for refusal to renew under  
26 Subsection (a) of this article. A small employer  
27 carrier may not cancel the coverage of a covered  
28 employee or dependent except for the reasons specified  
29 for refusal to renew under Subsection (b) of this  
30 article.

31 Art. 26.86. (a) Except as provided by Article  
32 26.87 of this code, a large employer carrier shall  
33 renew the large employer health benefit plans for a  
34 covered large employer, at the option of the large  
35 employer, unless:

36 (1) a premium has not been paid as required  
37 by the terms of the plan;

38 (2) the large employer has committed fraud  
39 or intentional misrepresentation of a material fact;

40 (3) the large employer has not complied  
41 with the terms of the health benefit plan;

42 (4) no enrollee in connection with the  
43 plan resides or works in the service area of the large  
44 employer carrier or in the area for which the large  
45 employer carrier is authorized to do business; or

46 (5) membership of an employer in an  
47 association terminates, but only if coverage is  
48 terminated uniformly without regard to a health status  
49 related factor of a covered individual.

50 (b) A large employer carrier may refuse to renew  
51 the coverage of an eligible employee or dependent for  
52 fraud or intentional misrepresentation of a material  
53 fact by that individual.

54 (c) A large employer carrier may not cancel a  
55 large employer health benefit plan except for the  
56 reasons specified for refusal to renew under  
57 Subsection (a) of this article. A large employer  
58 carrier may not cancel the coverage of an eligible  
59 employee or dependent except for the reasons specified  
60 for refusal to renew under Subsection (b) of this  
61 article.

62 Revisor's Note

63 Subsection (b), V.T.I.C. Article 26.23, provides  
64 that a small employer carrier may refuse to renew the

1 coverage of "a covered employee or dependent" for  
2 fraud or intentional misrepresentation. Subsection  
3 (b), V.T.I.C. Article 26.86, provides that a large  
4 employer carrier may refuse to renew the coverage of  
5 "an eligible employee or dependent" for fraud or  
6 intentional misrepresentation. Similarly, Subsection  
7 (c), V.T.I.C. Article 26.23, provides that a small  
8 employer carrier may not cancel the coverage of "a  
9 covered employee or dependent" except for the reasons  
10 specified for refusal to renew under Subsection (b),  
11 and Subsection (c), V.T.I.C. Article 26.86, provides  
12 that a large employer carrier may not cancel the  
13 coverage of "an eligible employee or dependent" except  
14 for the reasons specified for refusal to renew under  
15 Subsection (b). The revised law refers only to "a  
16 covered employee or dependent" because before a small  
17 or large employer health benefit plan issuer may  
18 refuse to renew or cancel an employee's or dependent's  
19 coverage, the employee or dependent must be covered.

20 Revised Law

21 Sec. 1501.109. REFUSAL TO RENEW; DISCONTINUATION OF  
22 COVERAGE. (a) A small or large employer health benefit plan  
23 issuer may elect to refuse to renew all small or large employer  
24 health benefit plans delivered or issued for delivery by the issuer  
25 in this state or in a geographic service area approved under Section  
26 1501.101. The issuer shall notify:

27 (1) the commissioner of the election not later than  
28 the 180th day before the date coverage under the first plan  
29 terminates under this subsection; and

30 (2) each affected covered small or large employer not  
31 later than the 180th day before the date coverage terminates for  
32 that employer.

33 (b) A small employer health benefit plan issuer that elects  
34 under this section to refuse to renew all small employer health

1 benefit plans in this state or in an approved geographic service  
2 area may not write a new small employer health benefit plan in this  
3 state or in the geographic service area, as applicable, before the  
4 fifth anniversary of the date notice is provided to the  
5 commissioner under Subsection (a).

6 (c) A large employer health benefit plan issuer that elects  
7 under this section to refuse to renew all large employer health  
8 benefit plans in this state or in an approved geographic service  
9 area may not write a new large employer health benefit plan in this  
10 state or in the geographic service area, as applicable, before the  
11 fifth anniversary of the date notice is provided to the  
12 commissioner under Subsection (a).

13 (d) A small or large employer health benefit plan issuer may  
14 elect to discontinue a particular type of small or large employer  
15 coverage only if the issuer:

16 (1) before the 90th day preceding the date of the  
17 discontinuation of the coverage:

18 (A) provides notice of the discontinuation to the  
19 employer and the commissioner; and

20 (B) offers to each employer the option to  
21 purchase other small or large employer coverage offered by the  
22 issuer at the time of the discontinuation; and

23 (2) acts uniformly without regard to the claims  
24 experience of the employer or any health status related factors of  
25 eligible employees, eligible employees' dependents, or new  
26 employees or dependents who may become eligible for the coverage.  
27 (V.T.I.C. Arts. 26.24, 26.87.)

28 Source Law

29 Art. 26.24. (a) A small employer carrier may  
30 elect to refuse to renew all small employer health  
31 benefit plans delivered or issued for delivery by the  
32 small employer carrier in this state or in a geographic  
33 service area approved under Article 26.22 of this  
34 code. The small employer carrier shall notify the  
35 commissioner of the election not later than the 180th  
36 day before the date coverage under the first small  
37 employer health benefit plan terminates under this  
38 subsection.

39 (b) The small employer carrier must notify each

1 affected covered small employer not later than the  
2 180th day before the date on which coverage terminates  
3 for that small employer.

4 (c) A small employer carrier that elects under  
5 Subsection (a) of this article to refuse to renew all  
6 small employer health benefit plans in this state or in  
7 an approved geographic service area may not write a new  
8 small employer health benefit plan in this state or in  
9 the geographic service area, as applicable, before the  
10 fifth anniversary of the date of notice to the  
11 commissioner under Subsection (a) of this article.

12 (d) A small employer carrier may elect to  
13 discontinue a particular type of small employer  
14 coverage only if the small employer carrier:

15 (1) before the 90th day preceding the date  
16 of the discontinuation of the coverage:

17 (A) provides notice of the  
18 discontinuation to the employer and the commissioner;  
19 and

20 (B) offers to each employer the  
21 option to purchase other small employer coverage  
22 offered by the small employer carrier at the time of  
23 the discontinuation; and

24 (2) acts uniformly without regard to the  
25 claims experience of the employer or any health status  
26 related factors of employees or dependents or new  
27 employees or dependents who may become eligible for  
28 the coverage.

29 Art. 26.87. (a) A large employer carrier may  
30 elect to refuse to renew all large employer health  
31 benefit plans delivered or issued for delivery by the  
32 large employer carrier in this state or in a geographic  
33 service area approved under Article 26.85 of this  
34 code. The large employer carrier shall notify the  
35 commissioner of the election not later than the 180th  
36 day before the date coverage under the first large  
37 employer health benefit plan terminates under this  
38 subsection.

39 (b) The large employer carrier shall notify each  
40 affected covered large employer not later than the  
41 180th day before the date on which coverage terminates  
42 for that large employer.

43 (c) A large employer carrier that elects under  
44 Subsection (a) of this article to refuse to renew all  
45 large employer health benefit plans in this state or in  
46 an approved geographic service area may not write a new  
47 large employer health benefit plan in this state or in  
48 the geographic service area, as applicable, before the  
49 fifth anniversary of the date on which notice is  
50 delivered to the commissioner under Subsection (a) of  
51 this article.

52 (d) A large employer carrier may elect to  
53 discontinue a particular type of large employer  
54 coverage only if the large employer carrier:

55 (1) before the 90th day preceding the date  
56 of the discontinuation of the coverage:

57 (A) provides notice of the  
58 discontinuation to the employer and the commissioner;  
59 and

60 (B) offers to each employer the  
61 option to purchase other large employer coverage  
62 offered by the large employer carrier at the time of  
63 the discontinuation; and

64 (2) acts uniformly without regard to the  
65 claims experience of the employer or any health status  
66 related factors of employees or dependents or new  
67 employees or dependents who may become eligible for

1 the coverage.

2 Revised Law

3 Sec. 1501.110. NOTICE TO COVERED PERSONS. (a) A small or  
4 large employer health benefit plan issuer that cancels or refuses  
5 to renew coverage under a small or large employer health benefit  
6 plan under Section 1501.108 or 1501.109 shall, not later than the  
7 30th day before the date termination of coverage is effective,  
8 notify the small or large employer of the cancellation of or refusal  
9 to renew coverage. The employer is responsible for notifying  
10 enrollees in the plan of the cancellation of or refusal to renew  
11 coverage.

12 (b) The notice provided to a small or large employer by a  
13 small or large employer health benefit plan issuer under this  
14 section is in addition to any other notice required by Section  
15 1501.109. (V.T.I.C. Arts. 26.25, 26.88.)

16 Source Law

17 Art. 26.25. (a) Not later than the 30th day  
18 before the date on which termination of coverage is  
19 effective, a small employer carrier that cancels or  
20 refuses to renew coverage under a small employer  
21 health benefit plan under Article 26.23 or 26.24 of  
22 this code shall notify the small employer of the  
23 cancellation or refusal to renew. It is the  
24 responsibility of the small employer to notify  
25 enrollees of the cancellation or refusal to renew the  
26 coverage.

27 (b) The notice provided to a small employer by a  
28 small employer carrier under this article is in  
29 addition to any other notice required by Article 26.23  
30 or 26.24 of this code.

31 Art. 26.88. (a) Not later than the 30th day  
32 before the date on which termination of coverage is  
33 effective, a large employer carrier that cancels or  
34 refuses to renew coverage under a large employer  
35 health benefit plan under Article 26.86 or 26.87 of  
36 this code shall notify the large employer of the  
37 cancellation or refusal to renew. It is the  
38 responsibility of the large employer to notify  
39 enrollees of the cancellation or refusal to renew the  
40 coverage.

41 (b) The notice provided to a large employer by a  
42 large employer carrier under this article is in  
43 addition to any other notice required by Article 26.86  
44 or 26.87 of this code.

45 Revisor's Note

46 Subsection (b), V.T.I.C. Article 26.25, refers to  
47 "notice required by Article 26.23 or 26.24 of this

code." Subsection (b), V.T.I.C. Article 26.88, refers to "notice required by Article 26.86 or 26.87 of this code." Articles 26.23 and 26.86 are revised as Section 1501.108, and Articles 26.24 and 26.87 are revised as Section 1501.109. The revised law omits the references to Articles 26.23 and 26.86 as unnecessary because those articles do not require a small or large employer health benefit plan issuer, respectively, to provide any notice.

#### Revised Law

Sec. 1501.111. WRITTEN STATEMENT OF DENIAL, CANCELLATION, OR REFUSAL TO RENEW REQUIRED. Denial by a small or large employer health benefit plan issuer of an application from a small or large employer for coverage from the issuer or cancellation of or refusal to renew coverage by a small or large employer health benefit plan issuer must:

- (1) be in writing; and
- (2) state the reason or reasons for the denial, cancellation, or refusal to renew. (V.T.I.C. Arts. 26.74, 26.94.)

#### Source Law

Art. 26.74. Denial by a small employer carrier of an application for coverage from a small employer or a cancellation or refusal to renew must be in writing and must state the reason or reasons for the denial, cancellation, or refusal.

Art. 26.94. Denial by a large employer carrier of an application for coverage from a large employer carrier or cancellation or refusal to renew must be in writing and must state the reason or reasons for the denial, cancellation, or refusal.

[Sections 1501.112-1501.150 reserved for expansion]

### SUBCHAPTER D. GUARANTEED ISSUE OF SMALL EMPLOYER HEALTH BENEFIT PLANS; CONTINUATION OF COVERAGE

#### Revised Law

Sec. 1501.151. GUARANTEED ISSUE. (a) A small employer health benefit plan issuer shall issue the small employer health benefit plan chosen by the small employer to each small employer that elects to be covered under the plan and agrees to satisfy the

1 other requirements of the plan.

2 (b) A small employer health benefit plan issuer shall  
3 provide small employer health benefit plans without regard to  
4 health status related factors.

5 (c) This chapter does not require a small employer to  
6 purchase health coverage for the employer's employees. (V.T.I.C.  
7 Art. 26.21, Subsecs. (a), (c) (part).)

8 Source Law

9 Art. 26.21. (a) Each small employer carrier  
10 shall provide the small employer health benefit plans  
11 without regard to health status related factors. Each  
12 small employer carrier shall issue the plan chosen by  
13 the small employer to each small employer that elects  
14 to be covered under that plan and agrees to satisfy the  
15 other requirements of the plan.

16 (c) . . . This chapter does not require a small  
17 employer to purchase health insurance coverage for the  
18 employer's employees.

19 Revised Law

20 Sec. 1501.152. EXCLUSION OF ELIGIBLE EMPLOYEE OR DEPENDENT  
21 PROHIBITED. A small employer health benefit plan issuer may not  
22 exclude an eligible employee or dependent, including a late  
23 enrollee, who would otherwise be covered under a small employer  
24 group. (V.T.I.C. Art. 26.21, Subsec. (1).)

25 Source Law

26 (1) A small employer carrier may not exclude any  
27 eligible employee or dependent, including a late  
28 enrollee, who would otherwise be covered under a small  
29 employer group.

30 Revised Law

31 Sec. 1501.153. EMPLOYER CONTRIBUTION. (a) This chapter  
32 does not require a small employer to make an employer contribution  
33 to the premium paid to a small employer health benefit plan issuer,  
34 but the issuer may require an employer contribution in accordance  
35 with the issuer's usual and customary practices applicable to the  
36 issuer's employer group health benefit plans in this state. The  
37 issuer shall apply the employer contribution level uniformly to  
38 each small employer offered or issued coverage by the issuer in this  
39 state.

1 (b) If two or more small employer health benefit plan  
2 issuers participate in a purchasing cooperative established under  
3 Section 1501.056, each participating issuer may use the employer  
4 contribution requirement established by the cooperative for  
5 policies marketed by the cooperative.

6 (c) A small employer that elects to make an employer  
7 contribution to the premium paid to a small employer health benefit  
8 plan issuer is not required to pay any amount with respect to an  
9 employee who elects not to be covered.

10 (d) A small employer may elect to pay the premium for  
11 additional coverage. (V.T.I.C. Art. 26.21, Subsecs. (b) (part),  
12 (c) (part).)

#### 13 Source Law

14 (b) This article does not impose a statutory  
15 mandate of an employer contribution to the premium  
16 paid to the small employer carrier. However, the small  
17 employer carrier may require an employer contribution  
18 in accordance with the carrier's usual and customary  
19 practices on all employer group health insurance plans  
20 in this state. The premium contribution level shall be  
21 applied uniformly to each small employer offered or  
22 issued coverage by the small employer carrier in this  
23 state. If two or more small employer carriers  
24 participate in a purchasing cooperative established  
25 under Article 26.14 of this code, the carrier may use  
26 the contribution requirement established by the  
27 purchasing cooperative for policies marketed by the  
28 cooperative. . . .

29 (c) . . . A small employer who elects to make  
30 contributions for payment of the premium is not  
31 required to pay any amount with respect to an employee  
32 who elects not to be covered. The small employer may  
33 elect to pay the premium cost for additional  
34 coverage. . . .

#### 35 Revised Law

36 Sec. 1501.154. MINIMUM PARTICIPATION REQUIREMENT. (a)  
37 Except as provided by Section 1501.155, coverage is available under  
38 a small employer health benefit plan if at least 75 percent of a  
39 small employer's eligible employees elect to participate in the  
40 plan.

41 (b) If a small employer offers multiple health benefit  
42 plans, the collective participation in those plans must be at  
43 least:

44 (1) 75 percent of the employer's eligible employees;

1 or

2 (2) if applicable, the lower participation level  
3 offered by the small employer health benefit plan issuer under  
4 Section 1501.155.

5 (c) A small employer health benefit plan issuer may elect  
6 not to offer a health benefit plan to a small employer that offers  
7 multiple health benefit plans if:

8 (1) the plans are provided by more than one issuer;

9 (2) the issuer would have less than 75 percent of the  
10 employer's eligible employees enrolled in the issuer's plan; and

11 (3) the issuer's plan is not provided through a  
12 purchasing cooperative. (V.T.I.C. Art. 26.21, Subsecs. (b)  
13 (part), (c) (part).)

14 Source Law

15 (b) . . . Coverage is available under a small  
16 employer health benefit plan if at least 75 percent of  
17 a small employer's eligible employees elect to be  
18 covered.

19 (c) If a small employer offers multiple health  
20 benefit plans, the collective enrollment of all of  
21 those plans must be at least 75 percent of the small  
22 employer's eligible employees or, if applicable, the  
23 lower participation level offered by the small  
24 employer carrier under Subsection (d) of this article.  
25 A small employer carrier may elect not to offer health  
26 benefit plans to a small employer who offers multiple  
27 health benefit plans if such plans are to be provided  
28 by more than one carrier and the small employer carrier  
29 would have less than 75 percent of the small employer's  
30 eligible employees enrolled in the small employer  
31 carrier's health benefit plan unless the coverage is  
32 provided through a purchasing cooperative. . . .

33 Revised Law

34 Sec. 1501.155. EXCEPTION TO MINIMUM PARTICIPATION  
35 REQUIREMENT. (a) A small employer health benefit plan issuer may  
36 offer a small employer health benefit plan to a small employer with  
37 a participation level of less than 75 percent of the employer's  
38 eligible employees if the issuer permits the same qualifying  
39 participation level for each small employer health benefit plan  
40 offered by the issuer in this state.

41 (b) A small employer health benefit plan issuer may offer a  
42 small employer health benefit plan to a small employer even if the

1 employer's participation level is less than the issuer's qualifying  
2 participation level established in accordance with Subsection (a)  
3 if:

4 (1) the employer obtains a written waiver from each  
5 eligible employee who declines coverage under a health benefit plan  
6 offered to the employer stating that the employee was not induced or  
7 pressured to decline coverage because of the employee's risk  
8 characteristics; and

9 (2) the issuer accepts or rejects the entire group of  
10 eligible employees who choose to participate and excludes only  
11 those employees who have declined coverage.

12 (c) A small employer health benefit plan issuer may  
13 underwrite the group of eligible employees who do not decline  
14 coverage under Subsection (b).

15 (d) A small employer health benefit plan issuer may not  
16 provide coverage to a small employer or the employer's employees  
17 under Subsection (b) if the issuer or an agent for the issuer knows  
18 that the employer has induced or pressured an eligible employee or a  
19 dependent of the employee to decline coverage because of the  
20 individual's risk characteristics.

21 (e) A small employer health benefit plan issuer, a small  
22 employer, or an agent may not use the exception provided by  
23 Subsection (b) to circumvent the requirements of this chapter.  
24 (V.T.I.C. Art. 26.21, Subsecs. (d), (e), (f).)

25 Source Law

26 (d) A small employer carrier may offer small  
27 employer health benefit plans to a small employer even  
28 if less than 75 percent of the eligible employees of  
29 that employer elect to be covered if the small employer  
30 carrier permits the same percentage of participation  
31 as a qualifying percentage for each small employer  
32 benefit plan offered by that carrier in this state. A  
33 small employer carrier may offer small employer health  
34 benefit plans to a small employer even if the  
35 employer's participation level is less than the small  
36 employer carrier's qualifying participation level  
37 established in accordance with this article if:

38 (1) the small employer obtains a written  
39 waiver for each eligible employee who declines  
40 coverage under a health plan offered to the small  
41 employer ensuring that the eligible employee was not  
42 induced or pressured into declining coverage because

1 of the employee's risk characteristics; and

2 (2) the small employer carrier accepts or  
3 rejects the entire group of eligible employees that  
4 choose to participate and excludes only those  
5 employees that have declined coverage, provided that  
6 the carrier may underwrite the group of eligible  
7 employees that do not decline coverage.

8 (e) A small employer carrier may not provide  
9 coverage to a small employer or the employees of a  
10 small employer under Subsection (d)(2) of this article  
11 if the health carrier or an agent for the health  
12 carrier knows that the small employer has induced or  
13 pressured an eligible employee or the employee's  
14 dependents to decline coverage because of an  
15 individual's risk characteristics.

16 (f) A small employer carrier, an employer, or an  
17 agent may not use the provisions of Subsection (d)(2)  
18 of this article to circumvent the requirements of this  
19 chapter.

#### 20 Revised Law

21 Sec. 1501.156. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a)

22 The initial enrollment period under a small employer health benefit  
23 plan for employees and dependents must be at least 31 days, with a  
24 31-day open enrollment period provided annually.

25 (b) A small employer may establish a waiting period not to  
26 exceed 90 days from the first day of employment.

27 (c) A small employer health benefit plan issuer may not deny  
28 coverage to a new employee of a covered small employer or the  
29 employee's dependents if the issuer receives an application for  
30 coverage not later than the 31st day after the date employment  
31 begins or on completion of a waiting period established under  
32 Subsection (b).

33 (d) A small employer health benefit plan issuer may deny  
34 coverage to a late enrollee until the next annual open enrollment  
35 period and may subject the enrollee to a one-year preexisting  
36 condition provision as described by Section 1501.102. The period  
37 during which the preexisting condition provision applies may not  
38 exceed 18 months from the date of the initial application.  
39 (V.T.I.C. Art. 26.21, Subsecs. (h), (i), (j), (k).)

#### 40 Source Law

41 (h) The initial enrollment period for the  
42 employees and their dependents must be at least 31  
43 days, with a 31-day open enrollment period provided  
44 annually.

45 (i) A small employer may establish a waiting  
46 period during which a new employee is not eligible for

1 coverage. A waiting period established as provided by  
2 this subsection may not exceed 90 days from the first  
3 day of employment.

4 (j) A new employee of a covered small employer  
5 and the dependents of that employee may not be denied  
6 coverage if the application for coverage is received  
7 by the small employer carrier not later than the 31st  
8 day after the date on which the employment begins or on  
9 completion of a waiting period established by the  
10 employer under Subsection (i) of this article.

11 (k) A late enrollee may be excluded from  
12 coverage until the next annual open enrollment period  
13 and may be subject to a 12-month preexisting condition  
14 provision as described by Article 26.49 of this code.  
15 The period during which a preexisting condition  
16 provision is imposed may not exceed 18 months from the  
17 date of the initial application.

#### 18 Revisor's Note

19 Subsection (i), V.T.I.C. Article 26.21, provides  
20 that a small employer may establish a waiting period  
21 "during which a new employee is not eligible for  
22 coverage." The revised law omits the quoted language  
23 as unnecessary because Subdivision (33), V.T.I.C.  
24 Article 26.02, as amended by Chapter 608, Acts of the  
25 77th Legislature, Regular Session, 2001, and  
26 Subdivision (34), V.T.I.C. Article 26.02, as amended  
27 by Chapter 823, Acts of the 77th Legislature, Regular  
28 Session, 2001, revised as Section 1501.002(17), define  
29 "waiting period" as "a period established by an  
30 employer that must pass before an individual who is a  
31 potential enrollee in a health benefit plan is  
32 eligible to be covered for benefits."

#### 33 Revised Law

34 Sec. 1501.157. COVERAGE FOR NEWBORN CHILDREN. (a) A  
35 small employer health benefit plan may not limit or exclude initial  
36 coverage of a newborn child of a covered employee.

37 (b) Coverage of a newborn child of a covered employee under  
38 this section ends on the 32nd day after the date of the child's  
39 birth unless, not later than the 31st day after the date of birth,  
40 the small employer health benefit plan issuer receives:

41 (1) notice of the birth; and

42 (2) any required additional premium. (V.T.I.C. Art.

1 26.21, Subsec. (n).)

2 Source Law

3 (n) A small employer health benefit plan may not  
4 limit or exclude initial coverage of a newborn child of  
5 a covered employee. Any coverage of a newborn child of  
6 an employee under this subsection terminates on the  
7 32nd day after the date of the birth of the child  
8 unless notification of the birth and any required  
9 additional premium are received by the small employer  
10 carrier not later than the 31st day after the date of  
11 birth.

12 Revised Law

13 Sec. 1501.158. COVERAGE FOR ADOPTED CHILDREN. (a) A  
14 small employer health benefit plan may not limit or exclude initial  
15 coverage of an adopted child of an insured. A child is considered  
16 to be the child of an insured if the insured is a party to a suit in  
17 which the insured seeks to adopt the child.

18 (b) An adopted child of an insured may be enrolled, at the  
19 insured's option, not later than the 31st day after:

20 (1) the date the insured becomes a party to a suit in  
21 which the insured seeks to adopt the child; or

22 (2) the date the adoption becomes final.

23 (c) Coverage of an adopted child of an insured under this  
24 section ends unless the small employer health benefit plan issuer  
25 receives notice of the adoption and any required additional premium  
26 not later than the 31st day after:

27 (1) the date the insured becomes a party to a suit in  
28 which the insured seeks to adopt the child; or

29 (2) the date the adoption becomes final. (V.T.I.C.  
30 Art. 26.21A.)

31 Source Law

32 Art. 26.21A. (a) A small employer health  
33 benefit plan may not limit or exclude initial coverage  
34 of an adopted child of an insured. A child is  
35 considered to be the child of an insured if the insured  
36 is a party in a suit in which the adoption of the child  
37 by the insured is sought.

38 (b) The adopted child of an insured may be  
39 enrolled, at the option of the insured, within either:

40 (1) 31 days after the insured is a party in  
41 a suit for adoption; or

42 (2) 31 days of the date the adoption is  
43 final.

44 (c) Coverage of an adopted child of an employee

1 under this article terminates unless notification of  
2 the adoption and any required additional premiums are  
3 received by the small employer carrier not later than  
4 either:

5 (1) the 31st day after the insured becomes  
6 a party in a suit in which the adoption of the child by  
7 the insured is sought; or

8 (2) the 31st day after the date of the  
9 adoption.

#### 10 Revised Law

11 Sec. 1501.159. CONTINUATION OF COVERAGE FOR CERTAIN  
12 DEPENDENTS. An employee's dependent may choose to continue  
13 coverage under a small employer health benefit plan if:

14 (1) the dependent:

15 (A) is under one year of age; or

16 (B) has been covered by the small employer under  
17 a plan for at least one year;

18 (2) the dependent loses eligibility for coverage  
19 because of the death, divorce, or retirement of the employee, as  
20 provided by Subchapter G, Chapter 1251; and

21 (3) the Consolidated Omnibus Budget Reconciliation  
22 Act of 1985 (Pub. L. No. 99-272) does not require continuation or  
23 conversion coverage for dependents of an employee. (V.T.I.C. Art.  
24 26.21, Subsec. (o).)

#### 25 Source Law

26 (o) If the Consolidated Omnibus Budget  
27 Reconciliation Act of 1985 (Pub. L. No. 99-272, 100  
28 Stat. 222) does not require continuation or conversion  
29 coverage for dependents of an employee, a dependent  
30 who has been covered by that small employer for at  
31 least one year or is under one year of age may elect to  
32 continue coverage under a small employer health  
33 benefit plan, if the dependent loses eligibility for  
34 coverage because of the death, divorce, or retirement  
35 of the employee, as required by Section 3B, Article  
36 3.51-6, of this code.

37 [Sections 1501.160-1501.200 reserved for expansion]

#### 38 SUBCHAPTER E. UNDERWRITING AND RATING OF SMALL EMPLOYER HEALTH 39 BENEFIT PLANS

#### 40 Revised Law

41 Sec. 1501.201. DEFINITIONS. In this subchapter:

42 (1) "Base premium rate" means, for each class of  
43 business and for a specific rating period, the lowest premium rate

1 that is charged or that could be charged under a rating system for  
2 that class of business by a small employer health benefit plan  
3 issuer to small employers with similar case characteristics for  
4 small employer health benefit plans that provide the same or  
5 similar coverage.

6 (2) "Case characteristics" means, with respect to a  
7 small employer, the geographic area in which the employer's  
8 employees reside, the age and gender of the individual employees  
9 and their dependents, the number of employees and dependents, the  
10 appropriate industry classification as determined by the small  
11 employer health benefit plan issuer, and other objective criteria  
12 established by the issuer that are considered by the issuer in  
13 setting premium rates for the employer. The term does not include:

14 (A) health status related factors;

15 (B) duration of coverage since the date of  
16 issuance of a health benefit plan; or

17 (C) whether a covered individual is or may become  
18 pregnant.

19 (3) "Class of business" means all small employers or a  
20 separate grouping of small employers established under this  
21 subchapter.

22 (4) "Index rate" means, for each class of business and  
23 for a specific rating period for small employers with similar case  
24 characteristics, the arithmetic average of the applicable base  
25 premium rate and corresponding highest premium rate.

26 (5) "New business premium rate" means, for each class  
27 of business and for a specific rating period, the lowest premium  
28 rate that is charged or offered or that could be charged or offered  
29 by a small employer health benefit plan issuer to small employers  
30 with similar case characteristics for newly issued small employer  
31 health benefit plans that provide the same or similar coverage.

32 (6) "Rating period" means a calendar period during  
33 which premium rates established by a small employer health benefit  
34 plan issuer are assumed to be in effect. (V.T.I.C. Art. 26.02,

Subdivs. (3), (5), (6), (14), (19), (26).)

Source Law

Art. 26.02. In this chapter:

(3) "Base premium rate" means, for each class of business and for a specific rating period, the lowest premium rate that is charged or that could be charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for small employer health benefit plans with the same or similar coverage.

(5) "Case characteristics" means, with respect to a small employer, the geographic area in which that employer's employees reside, the age and gender of the individual employees and their dependents, the appropriate industry classification as determined by the small employer carrier, the number of employees and dependents, and other objective criteria as established by the small employer carrier that are considered by the small employer carrier in setting premium rates for that small employer. The term does not include health status related factors, duration of coverage since the date of issuance of a health benefit plan, or whether a covered person is or may become pregnant.

(6) "Class of business" means all small employers or a separate grouping of small employers established under this chapter.

(14) "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and corresponding highest premium rate.

(19) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate that is charged or offered or that could be charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued small employer health benefit plans that provide the same or similar coverage.

(26) "Rating period" means a calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

Revised Law

Sec. 1501.202. ESTABLISHMENT OF CLASSES OF BUSINESS. (a) Except as otherwise provided by this subchapter, a small employer health benefit plan issuer may not establish a separate class or classes of business for small employers.

(b) A small employer health benefit plan issuer may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs

1 related to the following reasons:

2 (1) the issuer uses more than one type of system to  
3 market and sell small employer health benefit plans to small  
4 employers;

5 (2) the issuer has acquired a class of business from  
6 another small employer health benefit plan issuer; or

7 (3) the issuer provides coverage to one or more  
8 employer-based association groups.

9 (c) Except as provided by Subsection (e), a small employer  
10 health benefit plan issuer may not establish more than nine  
11 separate classes of business under this section.

12 (d) The commissioner may adopt rules to provide for a  
13 transition period to permit a small employer health benefit plan  
14 issuer to comply with Subsection (c) after acquiring an additional  
15 class of business from another small employer health benefit plan  
16 issuer.

17 (e) On application to the commissioner, the commissioner  
18 may approve the establishment of additional classes of business if  
19 the commissioner finds that the establishment of additional classes  
20 would enhance the efficiency and fairness of the health coverage  
21 market for small employers. (V.T.I.C. Art. 26.21, Subsec. (g);  
22 Art. 26.31, Subsecs. (a), (b), (c), (d).)

23 Source Law

24 [Art. 26.21]

25 (g) Except as otherwise provided by this  
26 chapter, a small employer carrier may not establish a  
27 separate class or classes of business for small  
28 employers.

29 Art. 26.31. (a) A small employer carrier may  
30 establish a separate class of business only to reflect  
31 substantial differences in expected claim experience  
32 or administrative costs related to the following  
33 reasons:

34 (1) the small employer carrier uses more  
35 than one type of system for the marketing and sale of  
36 small employer health benefit plans to small  
37 employers;

38 (2) the small employer carrier has  
39 acquired a class of business from another health  
40 carrier; or

41 (3) the small employer carrier provides  
42 coverage to one or more employer-based association  
43 groups.

1 (b) A small employer carrier may establish up to  
2 nine separate classes of business under this article.

3 (c) The commissioner may establish regulations  
4 to provide for a period of transition in order for a  
5 small employer carrier to come into compliance with  
6 Subsection (b) of this article in the instance of  
7 acquisition of an additional class of business from  
8 another small employer carrier.

9 (d) The commissioner may approve the  
10 establishment of additional classes of business on  
11 application to the commissioner and a finding by the  
12 commissioner that the establishment of additional  
13 classes would enhance the efficiency and fairness of  
14 the insurance market for small employers.

15 Revisor's Note

16 Subsection (c), V.T.I.C. Article 26.31, refers to  
17 "regulations." The revised law substitutes "rules" for  
18 "regulations" because under Section 311.005(5),  
19 Government Code (Code Construction Act), a rule is  
20 defined to include a regulation. That definition  
21 applies to the revised law.

22 Revised Law

23 Sec. 1501.203. ESTABLISHMENT OF CLASSES OF BUSINESS ON  
24 CERTAIN BASES PROHIBITED. (a) A small employer health benefit  
25 plan issuer may not establish a separate class of business based on:

26 (1) participation requirements; or

27 (2) whether the coverage provided to a small employer  
28 group is provided on a guaranteed issue basis or is subject to  
29 underwriting or proof of insurability.

30 (b) A small employer health benefit plan issuer may not  
31 directly or indirectly use as a criterion for establishing a  
32 separate class of business:

33 (1) the number of employees and dependents of a small  
34 employer; or

35 (2) except as provided by Section 1501.202(b)(3), the  
36 trade or occupation of the employees of a small employer or the  
37 industry or type of business of the small employer. (V.T.I.C. Art.  
38 26.31, Subsecs. (e), (f), (g).)

39 Source Law

40 (e) A small employer carrier may not establish a  
41 separate class of business based on participation  
42 requirements.

1 (f) A small employer carrier may not establish a  
2 separate class of business based on whether the  
3 coverage provided to a small employer group is  
4 provided on a guaranteed issue basis or is subject to  
5 underwriting or proof of insurability.

6 (g) A small employer carrier may not directly or  
7 indirectly use as a criterion for establishing a  
8 separate class of business:

9 (1) the number of employees and dependents  
10 of a small employer; or

11 (2) except as provided in Subsection  
12 (a)(3) of this article, the trade or occupation of the  
13 employees of a small employer or the industry or type  
14 of business of the small employer.

#### 15 Revised Law

16 Sec. 1501.204. INDEX RATES. Under a small employer health  
17 benefit plan:

18 (1) the index rate for a class of business may not  
19 exceed the index rate for any other class of business by more than  
20 20 percent; and

21 (2) premium rates charged during a rating period to  
22 small employers in a class of business with similar case  
23 characteristics for the same or similar coverage, or premium rates  
24 that could be charged to those employers under the rating system for  
25 that class of business, may not vary from the index rate by more  
26 than 25 percent. (V.T.I.C. Art. 26.32, Subsecs. (a), (b), (c).)

#### 27 Source Law

28 Art. 26.32. (a) The premium rates for a small  
29 employer health benefit plan are subject to this  
30 article.

31 (b) The index rate for a rating period for any  
32 class of business may not exceed the index rate for any  
33 other class of business by more than 20 percent.

34 (c) For a class of business, the premium rates  
35 charged during a rating period to small employers with  
36 similar case characteristics for the same or similar  
37 coverage, or the rates that could be charged to those  
38 employers under the rating system for that class of  
39 business, may not vary from the index rate by more than  
40 25 percent.

#### 41 Revisor's Note

42 Subsection (b), V.T.I.C. Article 26.32, refers to  
43 the index rate "for a rating period." The revised law  
44 omits the quoted language as unnecessary because the  
45 definition of "index rate" under Subdivision (14),  
46 V.T.I.C. Article 26.02, revised as Section  
47 1501.201(4), provides that an index rate is for a

1 particular rating period.

2 Revised Law

3 Sec. 1501.205. PREMIUM RATES: ESTABLISHMENT. (a) In this  
4 section:

5 (1) "Risk characteristic" means:

6 (A) a health status related factor;

7 (B) the duration of coverage; or

8 (C) any characteristic similar to a  
9 characteristic described by Paragraph (A) or (B) that is related to  
10 the health status or experience of a small employer group or of any  
11 member of a small employer group.

12 (2) "Risk load" means the percentage above the  
13 applicable base premium rate a small employer health benefit plan  
14 issuer charges to a small employer to reflect the risk  
15 characteristics associated with that particular small employer  
16 group.

17 (b) Small employer health benefit plan issuers shall  
18 develop premium rates for each small employer group in a two-step  
19 process. In the first step, the small employer health benefit plan  
20 issuer shall develop a base premium rate for each small employer  
21 group without regard to any risk characteristic of the group. In  
22 the second step, the small employer health benefit plan issuer may  
23 adjust the resulting base premium rate by the risk load of the  
24 group, subject to this subchapter, to reflect the risk  
25 characteristics of the group.

26 (c) The risk load assessed to a particular group shall  
27 reflect the risk characteristics of the particular group.  
28 (V.T.I.C. Art. 26.02, Subdivs. (28), (29), as amended Acts 77th  
29 Leg., R.S., Ch. 823; Art. 26.32, Subsecs. (d), (e).)

30 Source Law

31 Art. 26.02. [as amended Acts 77th Leg., R.S., Ch.  
32 823] In this chapter:

33 (28) "Risk characteristic" means:

34 (A) a health status related factor;

35 (B) the duration of coverage; or

36 (C) any characteristic similar to a

1 characteristic described by Paragraph (A) or (B) of  
2 this subdivision that is related to the health status  
3 or experience of a small employer group or of any  
4 member of a small employer group.

5 (29) "Risk load" means the percentage  
6 above the applicable base premium rate a small  
7 employer carrier charges to a small employer to  
8 reflect the risk characteristics associated with that  
9 particular small employer group.

10 [Art. 26.32]

11 (d) Small employer carriers shall develop  
12 premium rates for each small employer group in a  
13 two-step process. In the first step, the small  
14 employer carrier shall develop a base premium rate for  
15 each small employer group without regard to any risk  
16 characteristic of the group. In the second step, the  
17 small employer carrier may adjust the resulting base  
18 premium rate by the risk load of the group, subject to  
19 the provisions of this subchapter, to reflect the risk  
20 characteristics of the group.

21 (e) The risk load assessed to a particular group  
22 shall reflect the risk characteristics of the  
23 particular group.

24 Revised Law

25 Sec. 1501.206. PREMIUM RATES: ADJUSTMENTS. (a) The  
26 percentage increase in the premium rate charged to a small employer  
27 for a new rating period may not exceed the sum of:

28 (1) the percentage change in the new business premium  
29 rate, measured from the first day of the preceding rating period to  
30 the first day of the new rating period;

31 (2) any adjustment, not to exceed 15 percent annually  
32 and adjusted pro rata for a rating period of less than one year, due  
33 to the claims experience, health status, or duration of coverage of  
34 the employees or dependents of employees of the small employer, as  
35 determined under the small employer health benefit plan issuer's  
36 rate manual for the class of business; and

37 (3) any adjustment due to change in coverage or change  
38 in the case characteristics of the small employer, as determined  
39 under the issuer's rate manual for the class of business.

40 (b) An adjustment in the premium rate for claims experience,  
41 health status, or duration of coverage:

42 (1) may not be charged to individual employees or  
43 dependents; and

44 (2) must be applied uniformly to the rates charged for  
45 all employees and dependents of employees of the small employer.

1 (V.T.I.C. Art. 26.33, Subsecs. (a), (b).)

2 Source Law

3 Art. 26.33. (a) The percentage increase in the  
4 premium rate charged to a small employer for a new  
5 rating period may not exceed the sum of:

6 (1) the percentage change in the new  
7 business premium rate measured from the first day of  
8 the prior rating period to the first day of the new  
9 rating period;

10 (2) any adjustment, not to exceed 15  
11 percent annually and adjusted pro rata for rating  
12 periods of less than one year, due to the claim  
13 experience, health status, or duration of coverage of  
14 the employees or dependents of the small employer as  
15 determined from the small employer carrier's rate  
16 manual for the class of business; and

17 (3) any adjustment due to change in  
18 coverage or change in the case characteristics of the  
19 small employer as determined from the small employer  
20 carrier's rate manual for the class of business.

21 (b) Adjustments in premium rates for claim  
22 experience, health status, or duration of coverage may  
23 not be charged to individual employees or dependents.  
24 Such an adjustment must be applied uniformly to the  
25 rates charged for all employees and dependents of  
26 employees of the small employer.

27 Revised Law

28 Sec. 1501.207. PREMIUM RATE ADJUSTMENT IN CLOSED PLAN. For  
29 a closed health benefit plan under which a small employer health  
30 benefit plan issuer is no longer enrolling new small employers, the  
31 issuer shall use the percentage change in the base premium rate to  
32 adjust premium rates under Section 1501.206(a)(1). The portion of  
33 change in premium rates computed under that subdivision may not  
34 exceed, on a percentage basis, the change in the new business  
35 premium rate for the most similar health benefit plan under which  
36 the issuer is enrolling new small employers. (V.T.I.C. Art.  
37 26.35.)

38 Source Law

39 Art. 26.35. In the case of a health benefit plan  
40 into which a small employer carrier is no longer  
41 enrolling new small employers, the small employer  
42 carrier shall use the percentage change in the base  
43 premium rate to adjust rates under Articles  
44 26.33(a)(1) and 26.34(1) of this code. The portion of  
45 change in rates computed under those subdivisions may  
46 not exceed, on a percentage basis, the change in the  
47 new business premium rate for the most similar health  
48 benefit plan into which the small employer carrier is  
49 actively enrolling new small employers.

1                                   Revisor's Note

2                   V.T.I.C. Article 26.35 refers to "Articles  
3                   26.33(a)(1) and 26.34(1) of this code." The revised  
4                   law omits the reference to Article 26.34(1) because  
5                   Article 26.34 is omitted from this revision. See the  
6                   revisor's note at the end of this subchapter.

7                                   Revised Law

8                   Sec. 1501.208. PREMIUM RATES: INDUSTRY CLASSIFICATION. A  
9                   small employer health benefit plan issuer may use the industry  
10                  classification to which a small employer belongs as a case  
11                  characteristic in establishing the premium rate, but the highest  
12                  rate factor associated with any industry classification may not  
13                  exceed by more than 15 percent the lowest rate factor associated  
14                  with any industry classification. (V.T.I.C. Art. 26.33, Subsec.  
15                  (c).)

16                                  Source Law

17                  (c) A health carrier may use the industry  
18                  classification to which a small employer belongs as a  
19                  case characteristic in establishing premium rates, but  
20                  the highest rate factor associated with any industry  
21                  classification may not exceed the lowest rate factor  
22                  associated with any industry classification by more  
23                  than 15 percent.

24                                  Revised Law

25                  Sec. 1501.209. PREMIUM RATES: NUMBER OF EMPLOYEES. A small  
26                  employer health benefit plan issuer may use the number of employees  
27                  and dependents of a small employer as a case characteristic in  
28                  establishing premium rates for the group. The highest rate factor  
29                  associated with a classification based on the number of employees  
30                  and dependents of a small employer may not exceed by more than 20  
31                  percent the lowest rate factor associated with a classification  
32                  based on the number of employees and dependents of a small employer.  
33                  (V.T.I.C. Art. 26.33, Subsec. (d).)

34                                  Source Law

35                  (d) A small employer carrier may use the number  
36                  of employees and dependents of a small employer as a  
37                  case characteristic in establishing premium rates for  
38                  the group. The highest rate factor associated with a  
39                  classification based on the number of employees and

dependents of a small employer may not exceed by more than 20 percent the lowest rate factor associated with a classification based on the number of employees and dependents of a small employer.

Revised Law

Sec. 1501.210. PREMIUM RATES: NONDISCRIMINATION. (a) A small employer health benefit plan issuer shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premium rates for identical groups that:

(1) differ only by the amounts attributable to health benefit plan design; and

(2) do not reflect differences because of the nature of the groups assumed to select particular health benefit plans.

(b) A small employer health benefit plan issuer shall treat each health benefit plan issued or renewed in the same calendar month as having the same rating period.

(c) Without the prior approval of the commissioner, a small employer health benefit plan issuer may not use case characteristics other than:

(1) the geographic area in which the small employer's employees reside;

(2) the age and gender of the individual employees and their dependents;

(3) the number of employees and dependents; and

(4) the appropriate industry classification.

(d) Premium rates for a small employer health benefit plan must comply with the requirements of this chapter, notwithstanding any assessment paid or payable by a small employer health benefit plan issuer.

(e) A small employer health benefit plan issuer may not transfer a small employer involuntarily into or out of a class of business. The issuer may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all other small employers in the employer's class of business without regard to case characteristics, claims

1 experience, health status, or duration of coverage since the  
2 issuance of the health benefit plan. (V.T.I.C. Art. 26.36,  
3 Subsecs. (a), (b), (c), (d), (f).)

4 Source Law

5 Art. 26.36. (a) A small employer carrier shall  
6 apply rating factors, including case characteristics,  
7 consistently with respect to all small employers in a  
8 class of business. Rating factors shall produce  
9 premiums for identical groups that differ only by the  
10 amounts attributable to plan design and that do not  
11 reflect differences due to the nature of the groups  
12 assumed to select particular health benefit plans.

13 (b) A small employer carrier shall treat each  
14 health benefit plan issued or renewed in the same  
15 calendar month as having the same rating period.

16 (c) A small employer carrier may not use case  
17 characteristics without the prior approval of the  
18 commissioner other than the geographic area in which  
19 the small employer's employees reside, the age and  
20 gender of the individual employees and their  
21 dependents, the appropriate industry classification,  
22 and the number of employees and dependents.

23 (d) Premium rates for a small employer health  
24 benefit plan must comply with the requirements of this  
25 chapter, notwithstanding any assessments paid or  
26 payable by small employer carriers.

27 (f) A small employer carrier may not transfer a  
28 small employer involuntarily into or out of a class of  
29 business. A small employer carrier may not offer to  
30 transfer a small employer into or out of a class of  
31 business unless the offer is made to transfer all small  
32 employers in that class of business without regard to  
33 case characteristics, claim experience, health  
34 status, or duration of coverage since the issuance of  
35 the health benefit plan.

36 Revised Law

37 Sec. 1501.211. RULES CONCERNING PREMIUM RATES. Rules  
38 adopted under Section 1501.010 may ensure that:

39 (1) rating practices used by small employer health  
40 benefit plan issuers are consistent with the purposes of this  
41 chapter; and

42 (2) differences in premium rates charged for each  
43 small employer health benefit plan are reasonable and reflect  
44 objective differences in plan design. (V.T.I.C. Art. 26.36,  
45 Subsec. (e).)

46 Source Law

47 (e) The board may adopt rules to implement this  
48 article and to ensure that rating practices used by  
49 small employer carriers are consistent with the  
50 purposes of this chapter, including rules that ensure

1 that differences in rates charged for each small  
2 employer health benefit plan are reasonable and  
3 reflect objective differences in plan design.

4 Revisor's Note

5 (1) Subsection (e), V.T.I.C. Article 26.36,  
6 refers to the "board," meaning the State Board of  
7 Insurance. Chapter 685, Acts of the 73rd Legislature,  
8 Regular Session, 1993, abolished the State Board of  
9 Insurance and transferred its functions to the  
10 commissioner of insurance and the Texas Department of  
11 Insurance. Throughout this chapter, references to the  
12 State Board of Insurance have been changed  
13 appropriately.

14 (2) Subsection (e), V.T.I.C. Article 26.36,  
15 provides that the State Board of Insurance "may adopt  
16 rules to implement this article." V.T.I.C. Article  
17 26.04, revised as Section 1501.010, requires the  
18 commissioner of insurance to adopt rules necessary to  
19 implement V.T.I.C. Chapter 26. Accordingly, the  
20 revised law omits the portion of Subsection (e),  
21 Article 26.36, authorizing the adoption of rules and  
22 substitutes a cross-reference to Section 1501.010.

23 Revised Law

24 Sec. 1501.212. RESTRICTED PROVIDER NETWORK. (a) A small  
25 employer health benefit plan may use a restricted provider network  
26 to provide benefits under the plan.

27 (b) A small employer health benefit plan that uses a  
28 restricted provider network does not provide similar coverage to a  
29 plan that does not use a restricted provider network if the use of  
30 the network results in reduced premium rates charged to the small  
31 employer or substantial differences in claim costs. (V.T.I.C. Art.  
32 26.37.)

33 Source Law

34 Art. 26.37. For purposes of this subchapter, a  
35 small employer health benefit plan may use a  
36 restricted provider network to provide the benefits  
37 under the plan. A plan that uses a restricted provider

1 network does not provide similar coverage to a small  
2 employer health benefit plan that does not use a  
3 restricted provider network, if the use of the network  
4 results in reduced premiums to the small employer or  
5 substantial differences in claim costs.

6 Revised Law

7 Sec. 1501.213. PREMIUM RATES: HEALTH MAINTENANCE  
8 ORGANIZATION HEALTH BENEFIT PLAN. (a) The premium rates for a  
9 state-approved health benefit plan offered by a health maintenance  
10 organization under Section 1501.255 must be established in  
11 accordance with formulas or schedules of charges filed with the  
12 department.

13 (b) A health maintenance organization that participates in  
14 a purchasing cooperative that provides employees of small employers  
15 a choice of health benefit plans may use rating methods in  
16 accordance with this subchapter that are used by other small  
17 employer health benefit plan issuers participating in the same  
18 cooperative, including rating by age and gender, if the health  
19 maintenance organization has established:

20 (1) a separate class of business, as provided by  
21 Section 1501.202; and

22 (2) a separate line of business, as provided under  
23 Section 1501.255(b) and Title XIII, Public Health Service Act (42  
24 U.S.C. Section 300e et seq.). (V.T.I.C. Art. 26.38.)

25 Source Law

26 Art. 26.38. (a) The premium rates for a  
27 state-approved health benefit plan offered by a health  
28 maintenance organization under Article 26.48 of this  
29 code must be established in accordance with formulas  
30 or schedules of charges filed with the department.

31 (b) A health maintenance organization that  
32 participates in a purchasing cooperative that provides  
33 employees of small employers a choice of benefit  
34 plans, that has established a separate class of  
35 business as provided by Article 26.31 of this code, and  
36 that has established a separate line of business as  
37 provided under Article 26.48(a) of this code and Title  
38 XIII, Public Health Service Act (42 U.S.C. Section  
39 300e et seq.) may use rating methods in accordance with  
40 this subchapter that are used by other small employer  
41 carriers participating in the same cooperative,  
42 including rating by age and gender.

43 Revised Law

44 Sec. 1501.214. ENFORCEMENT. If the commissioner determines

1 that a small employer health benefit plan issuer subject to this  
2 chapter exceeds the applicable premium rate established under this  
3 subchapter, the commissioner may order restitution and assess  
4 penalties as provided by Chapter 82. (V.T.I.C. Art. 26.39.)

5 Source Law

6 Art. 26.39. If the commissioner finds that a  
7 small employer carrier subject to this chapter exceeds  
8 the applicable rate established under this subchapter,  
9 the commissioner may order restitution and assess  
10 penalties as provided by Section 7, Article 1.10, of  
11 this code.

12 Revised Law

13 Sec. 1501.215. REPORTING REQUIREMENTS. (a) Annually, each  
14 small employer health benefit plan issuer that offers a small  
15 employer health benefit plan shall file with the commissioner an  
16 actuarial certification stating that the issuer's underwriting and  
17 rating methods:

18 (1) comply with accepted actuarial practices;

19 (2) are uniformly applied to each small employer  
20 health benefit plan covering a small employer; and

21 (3) comply with this subchapter.

22 (b) Each small employer health benefit plan issuer shall  
23 maintain at its principal place of business a complete and detailed  
24 description of its rating practices and renewal underwriting  
25 practices, including information and documentation that  
26 demonstrate that its rating methods and practices are based on  
27 commonly accepted actuarial assumptions and are in accordance with  
28 sound actuarial principles.

29 (c) A small employer health benefit plan issuer shall make  
30 the information and documentation described in Subsection (b)  
31 available to the commissioner on request. Unless the information  
32 or documentation relates to a violation of this chapter, the  
33 information or documentation is considered proprietary and trade  
34 secret information and is not subject to disclosure by the  
35 commissioner to a person outside the department except as agreed to  
36 by the issuer or as ordered by a court. (V.T.I.C. Art. 26.41.)

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1           comply with those articles. The omitted law reads:

2                     Art. 26.34. For a health benefit plan  
3                     delivered or issued for delivery before  
4                     September 1, 1993, a premium rate for a  
5                     rating period may exceed the ranges set  
6                     forth in Articles 26.32 and 26.33 of this  
7                     code until September 1, 1995. The  
8                     percentage increase in the premium rate  
9                     charged to a small employer under this  
10                    article for a new rating period may not  
11                    exceed the sum of:

12                    (1) the percentage change in  
13                    the new business premium rate measured from  
14                    the first day of the prior rating period to  
15                    the first day of the new rating period; and

16                    (2) any adjustment due to  
17                    change in coverage or change in the case  
18                    characteristics of the small employer as  
19                    determined from the small employer  
20                    carrier's rate manual for the class of  
21                    business.

22           [Sections 1501.216-1501.250 reserved for expansion]

23       SUBCHAPTER F. COVERAGE UNDER SMALL EMPLOYER HEALTH BENEFIT PLANS

24                     Revised Law

25           Sec. 1501.251. EXCEPTION FROM CERTAIN MANDATED BENEFIT  
26       REQUIREMENTS. Except as expressly provided by this chapter, a  
27       small employer health benefit plan is not subject to a law that  
28       requires coverage or the offer of coverage of a health care service  
29       or benefit. (V.T.I.C. Art. 26.06, Subsec. (d).)

30                     Source Law

31                    (d) Except as expressly provided in this  
32                    chapter, a small employer health benefit plan is not  
33                    subject to a law that requires coverage or the offer of  
34                    coverage of a health care service or benefit.

35                     Revised Law

36           Sec. 1501.252. HEALTH BENEFIT PLANS. (a) A small  
37       employer health benefit plan issuer shall offer the following two  
38       health benefit plans as adopted by the commissioner:

39                    (1) the catastrophic care health benefit plan; and

40                    (2) the basic coverage health benefit plan.

41           (b) A small employer health benefit plan issuer may offer to  
42       a small employer additional benefit riders to either of the health  
43       benefit plans required by Subsection (a).

44           (c) Subject to this chapter, a small employer health benefit  
45       plan issuer may also offer to a small employer any other health

1 benefit plan authorized under this code. Section 1501.251 does not  
2 apply to a health benefit plan offered to a small employer under  
3 this subsection. (V.T.I.C. Art. 26.42.)

#### 4 Source Law

5 Art. 26.42. (a) A small employer carrier shall  
6 offer the following two health benefit plans as  
7 adopted by the commissioner:

8 (1) the catastrophic care benefit plan;  
9 and

10 (2) the basic coverage benefit plan.

11 (b) A small employer carrier may offer to a  
12 small employer additional benefit riders to either of  
13 the benefit plans.

14 (c) Subject to the provisions of this chapter, a  
15 small employer carrier may also offer to small  
16 employers any other health benefit plan authorized  
17 under this code. Article 26.06(c) does not apply to a  
18 health benefit plan offered to a small employer under  
19 this subsection.

#### 20 Revisor's Note

21 Subsection (c), V.T.I.C. Article 26.42, provides  
22 that "Article 26.06(c)" of this code does not apply to  
23 certain health benefit plans offered by a small  
24 employer carrier. As originally enacted in 1993,  
25 Subsection (c), Article 26.06, provided that "[e]xcept  
26 as expressly provided in this chapter, a small  
27 employer health benefit plan is not subject to a law  
28 that requires coverage or the offer of coverage of a  
29 health care service or benefit." Article 26.06 was  
30 amended by Section 1.05, Chapter 955, Acts of the 75th  
31 Legislature, Regular Session, 1997. The 1997  
32 amendment added a new Subsection (b) to Article 26.06  
33 and relettered existing Subsections (b) and (c) as (c)  
34 and (d), respectively. However, the 1997 amendment  
35 failed to correct the cross-reference in Article  
36 26.42. The revised law is drafted to correct that  
37 cross-reference.

#### 38 Revised Law

39 Sec. 1501.253. COVERAGE REQUIREMENTS. (a) The  
40 commissioner by rule shall establish coverage requirements for the  
41 catastrophic care health benefit plan and the basic coverage health

1 benefit plan.

2 (b) Coverage under the catastrophic care health benefit  
3 plan must be designed to provide necessary coverage in the event of  
4 catastrophic illness or injury. The commissioner shall establish  
5 deductibles and coinsurance requirements at levels that permit  
6 options for a covered individual to obtain affordable catastrophic  
7 coverage.

8 (c) Coverage under the basic coverage health benefit plan  
9 must be designed to provide basic hospital, medical, and surgical  
10 coverage. Benefits under the plan are limited to basic care  
11 requirements for illness and injury.

12 (d) The benefits provisions of the catastrophic care and  
13 basic coverage health benefit plan policies must include:

- 14 (1) all required or applicable definitions;  
15 (2) a description of covered services required under  
16 the plan;  
17 (3) a list of any exclusions or limitations to  
18 coverage; and  
19 (4) the deductible and coinsurance options that are  
20 required or permitted under the plan. (V.T.I.C. Art. 26.44A,  
21 Subsecs. (a) (part), (b), (c), (d).)

22 Source Law

23 Art. 26.44A. (a) The commissioner by rule shall  
24 establish the coverage requirements for the  
25 catastrophic care benefit plan and the basic coverage  
26 benefit plan. . . .

27 (b) Coverage under the catastrophic care  
28 benefit plan must be designed to provide necessary  
29 coverage in the event of catastrophic illness or  
30 injury. The commissioner shall establish deductibles  
31 and coinsurance requirements at levels that permit  
32 options for the insured to obtain affordable  
33 catastrophic coverage.

34 (c) The commissioner by rule shall establish  
35 coverage requirements for the basic coverage benefit  
36 plan. Coverage under the basic coverage benefit plan  
37 must be designed to provide basic hospital, medical,  
38 and surgical coverages. Benefits under the plan are  
39 limited to basic care requirements for illness and  
40 injury.

41 (d) The benefits provisions of the benefit plan  
42 policies must include the following:

- 43 (1) all required or applicable  
44 definitions;  
45 (2) a list of any exclusions or

1 limitations to coverage;  
2 (3) a description of covered services  
3 required under the plan; and  
4 (4) the deductible and coinsurance options  
5 that are required or permitted under the plan.

6 Revised Law

7 Sec. 1501.254. ALCOHOL AND SUBSTANCE ABUSE BENEFITS. (a)  
8 This section applies only if the basic coverage health benefit plan  
9 developed by the commissioner under Section 1501.253 includes  
10 coverage for alcohol and substance abuse benefits.

11 (b) A small employer health benefit plan issuer may offer  
12 and the employees of a small employer group may accept a basic  
13 coverage health benefit plan without coverage for alcohol and  
14 substance abuse benefits if:

- 15 (1) at least 50 percent of the employees in writing:  
16 (A) waive the benefits; and  
17 (B) indicate that they have undergone alcoholism  
18 or substance abuse treatment or counseling within the preceding  
19 three years; and  
20 (2) the exclusion of those benefits applies only to  
21 those employees. (V.T.I.C. Art. 26.44B.)

22 Source Law

23 Art. 26.44B. If the small employer basic  
24 coverage benefit plan developed by the commissioner  
25 includes coverage for alcohol and substance abuse  
26 benefits, the employees of a small employer group may  
27 accept and small employer carriers may offer the basic  
28 coverage benefit plan without providing coverage for  
29 alcohol and substance abuse benefits if:

- 30 (1) at least 50 percent of the employees  
31 waive in writing the benefits and indicate in writing  
32 that they have undergone alcoholism or substance abuse  
33 treatment or counseling within the last three years;  
34 and  
35 (2) the exclusion from coverage of alcohol  
36 and substance abuse applies to only those employees.

37 Revised Law

38 Sec. 1501.255. HEALTH MAINTENANCE ORGANIZATION PLANS. (a)  
39 In this section, "point-of-service contract" means a health benefit  
40 plan offered through a health maintenance organization that:

- 41 (1) includes corresponding indemnity benefits in  
42 addition to benefits relating to out-of-area or emergency services  
43 provided through insurers or group hospital service corporations;

1 and

2 (2) permits the covered individual to obtain coverage  
3 under either the health maintenance organization conventional plan  
4 or the indemnity plan as determined in accordance with the terms of  
5 the contract.

6 (b) A health maintenance organization may offer:

7 (1) a state-approved health benefit plan that complies  
8 with this chapter, Chapters 843, 1271, 1272, and 1367, Subchapter  
9 A, Chapter 1452, Title XIII, Public Health Service Act (42 U.S.C.  
10 Section 300e et seq.), and its subsequent amendments, and rules  
11 adopted under those laws;

12 (2) a health benefit plan developed by the  
13 commissioner under Section 1501.253 and additional benefit riders  
14 to the plan; or

15 (3) a point-of-service contract in connection with an  
16 insurer that includes optional coverage for out-of-area services,  
17 emergency care, or out-of-network care.

18 (c) A point-of-service contract offered under Subsection  
19 (b)(3) is subject to this chapter unless specifically exempted.  
20 The insurer with which the health maintenance organization offers a  
21 point-of-service contract is not required to otherwise make  
22 available the health benefit plans adopted under this subchapter if  
23 the insurer's small employer products are limited to the  
24 point-of-service contract. (V.T.I.C. Art. 26.02, Subdiv. (23);  
25 Art. 26.48.)

26 Source Law

27 Art. 26.02. In this chapter:

28 (23) "Point-of-service contract" means a  
29 benefit plan offered through a health maintenance  
30 organization that:

31 (A) includes corresponding indemnity  
32 benefits in addition to benefits relating to  
33 out-of-area or emergency services provided through  
34 insurers or group hospital service corporations; and

35 (B) permits the insured to obtain  
36 coverage under either the health maintenance  
37 organization conventional plan or the indemnity plan  
38 as determined in accordance with the terms of the  
39 contract.

1           Art. 26.48. (a) A health maintenance  
2 organization may offer:

3           (1) a state-approved health benefit plan  
4 that complies with this chapter, the Texas Health  
5 Maintenance Organization Act (Chapter 20A, Vernon's  
6 Texas Insurance Code), Title XIII, Public Health  
7 Service Act (42 U.S.C. Section 300e et seq.), and its  
8 subsequent amendments, and rules adopted under these  
9 laws;

10           (2) a plan developed by the commissioner  
11 under Article 26.44A of this code and additional  
12 benefit riders to the plan; or

13           (3) a point-of-service contract in  
14 connection with an insurance carrier that includes  
15 optional coverage for out-of-area services, emergency  
16 care, or out-of-network care.

17           (b) A contract offered by an insurance carrier  
18 under Subsection (a)(3) of this article is subject to  
19 all provisions of this chapter unless specifically  
20 exempted. The insurance carrier with which the health  
21 maintenance organization contracts for a  
22 point-of-service contract is not required to otherwise  
23 make available the benefit plans adopted under  
24 Subchapter E of this chapter if the insurance carrier's  
25 small employer products are limited to the  
26 point-of-service contract.

27                           Revisor's Note

28           Subsection (a)(1), V.T.I.C. Article 26.48,  
29 authorizes a health maintenance organization to offer  
30 a health benefit plan that complies with, among other  
31 statutes, the Texas Health Maintenance Organization  
32 Act (Chapter 20A, Vernon's Texas Insurance Code). A  
33 majority of V.T.I.C. Chapter 20A was revised in 2001 as  
34 Chapter 843 of this code. The remaining portions of  
35 Chapter 20A are revised in this code in Chapters 222  
36 and 258, which impose premium and maintenance taxes on  
37 health maintenance organizations; Chapter 1271, which  
38 deals with benefits provided by health maintenance  
39 organizations; Chapter 1272, which deals with  
40 delegated networks; Chapter 1367, in part, which  
41 requires health maintenance organizations to provide  
42 coverage for certain childhood immunizations; and  
43 Subchapter A, Chapter 1452, in part, which deals with  
44 credentialing of physicians and providers by health  
45 maintenance organizations. Because the issue of taxes  
46 is irrelevant in this context, the revised law does not  
47 refer to Chapter 222 or 258 of this code.

1                                    Revised Law

2            Sec. 1501.256. COORDINATION WITH FEDERAL LAW. (a) To the  
3 extent required to comply with federal law applicable to a small  
4 employer health benefit plan described by this subchapter, the  
5 commissioner by rule may:

6                    (1) modify the plan; or

7                    (2) adopt a substitute for the plan.

8            (b) The commissioner shall use the Texas Health Benefits  
9 Purchasing Cooperative in implementing this section. (V.T.I.C.  
10 Art. 26.50.)

11                                   Source Law

12            Art. 26.50. The board by rule may modify a small  
13 employer benefit plan described by this subchapter or  
14 adopt a substitute for that plan to the extent required  
15 to comply with federal law applicable to the plan. The  
16 board shall use the Texas Health Benefits Purchasing  
17 Cooperative in the implementation of this article.

18                                   Revised Law

19            Sec. 1501.257. COST CONTAINMENT. (a) A small employer  
20 health benefit plan issuer may use cost containment and managed  
21 care features in a small employer health benefit plan, including:

22                    (1) utilization review of health care services,  
23 including review of the medical necessity of hospital and physician  
24 services;

25                    (2) case management, including discharge planning and  
26 review of stays in hospitals or other health care facilities;

27                    (3) selective contracting with hospitals, physicians,  
28 and other health care providers;

29                    (4) reasonable benefit differentials applicable to  
30 health care providers that participate or do not participate in  
31 restricted network arrangements;

32                    (5) precertification or preauthorization for certain  
33 covered services; and

34                    (6) coordination of benefits.

35            (b) A provision of a small employer health benefit plan that  
36 provides for coordination of benefits must comply with this chapter

1 and guidelines established by the commissioner.

2 (c) Utilization review performed for any cost containment,  
3 case management, or managed care arrangement must comply with  
4 Article 21.58A. (V.T.I.C. Art. 26.08.)

5 Source Law

6 Art. 26.08. (a) A small employer carrier may  
7 use cost containment and managed care features in a  
8 small employer health benefit plan, including:

9 (1) utilization review of health care  
10 services, including review of the medical necessity of  
11 hospital and physician services;

12 (2) case management, including discharge  
13 planning and review of stays in hospitals or other  
14 health care facilities;

15 (3) selective contracting with hospitals,  
16 physicians, and other health care providers;

17 (4) reasonable benefit differentials  
18 applicable to health care providers that participate  
19 or do not participate in restricted network  
20 arrangements;

21 (5) precertification or preauthorization  
22 for certain covered services; and

23 (6) coordination of benefits.

24 (b) A provision of a small employer health  
25 benefit plan that provides for coordination of  
26 benefits must comply with this chapter and guidelines  
27 established by the commissioner.

28 (c) Utilization review performed for any cost  
29 containment, case management, or managed care  
30 arrangement must comply with Article 21.58A of this  
31 code.

32 Revised Law

33 Sec. 1501.258. FORMS. (a) The commissioner shall:

34 (1) prescribe the benefits section of the catastrophic  
35 care health benefit plan and the basic coverage health benefit plan  
36 policy forms in accordance with Section 1501.253; and

37 (2) develop prototype policies for each of the health  
38 benefit plans that include all contractual provisions required to  
39 produce an entire contract in accordance with this code.

40 (b) With regard to each portion of the policy form for the  
41 catastrophic care health benefit plan or the basic coverage health  
42 benefit plan, other than the benefits section, a small employer  
43 health benefit plan issuer shall comply with:

44 (1) Chapter 1701 as it relates to policy form  
45 approval; and

46 (2) Chapter 1271 as it relates to evidence of coverage

1 approval.

2 (c) A small employer health benefit plan issuer may not  
3 offer the catastrophic care health benefit plan or the basic  
4 coverage health benefit plan through a policy form or evidence of  
5 coverage that does not comply with this chapter. (V.T.I.C. Art.  
6 26.43, Subsec. (a); Art. 26.44A, Subsec. (a) (part).)

7 Source Law

8 Art. 26.43. (a) The commissioner shall  
9 promulgate the benefits section of the catastrophic  
10 care benefit plan and the basic coverage benefit plan  
11 policy forms in accordance with Article 26.44A of this  
12 code and shall develop prototype policies for each of  
13 the benefit plans. For all other portions of these  
14 policy forms, a small employer carrier shall comply  
15 with Article 3.42 of this code as it relates to policy  
16 form approval and with the Texas Health Maintenance  
17 Organization Act (Article 20A.01 et seq., Vernon's  
18 Texas Insurance Code) as it relates to approval of an  
19 evidence of coverage. A small employer carrier may not  
20 offer these benefit plans through a policy form or  
21 evidence of coverage that does not comply with this  
22 chapter.

23 Art. 26.44A. (a) . . . The commissioner shall  
24 develop prototype policies for use by small employer  
25 carriers that include all contractual provisions  
26 required to produce an entire contract in accordance  
27 with this article and this code.

28 Revisor's Note

29 Subsection (a), V.T.I.C. Article 26.43, requires  
30 a small employer health benefit plan issuer to comply  
31 with "the Texas Health Maintenance Organization Act  
32 (Article 20A.01 et seq., Vernon's Texas Insurance  
33 Code) as it relates to approval of an evidence of  
34 coverage." The relevant provisions of the Texas  
35 Health Maintenance Organization Act relating to  
36 approval of an evidence of coverage are revised in  
37 Chapter 1271 of this code, and the revised law is  
38 drafted accordingly.

39 Revised Law

40 Sec. 1501.259. RIDERS; FILING WITH COMMISSIONER. (a) A  
41 small employer health benefit plan issuer shall file with the  
42 commissioner, in a form and manner prescribed by the commissioner,  
43 each rider to a small employer health benefit plan to be used by the

1 issuer, as authorized by Section 1501.252.

2 (b) A small employer health benefit plan issuer may use a  
3 rider filed under this section after the 30th day after the date the  
4 rider is filed unless the commissioner disapproves its use.

5 (c) The commissioner, after notice and an opportunity for a  
6 hearing, may disapprove the continued use of a rider by a small  
7 employer health benefit plan issuer if the rider does not meet the  
8 requirements of this chapter and other applicable statutes.  
9 (V.T.I.C. Art. 26.44.)

10 Source Law

11 Art. 26.44. (a) A small employer carrier shall  
12 file with the commissioner, in a form and manner  
13 prescribed by the commissioner, riders to the small  
14 employer health benefit plans as allowed under Article  
15 26.42 of this code to be used by the small employer  
16 carrier. A small employer carrier may use a rider  
17 filed under this article after the 30th day after the  
18 date the rider is filed unless the commissioner  
19 disapproves its use.

20 (b) The commissioner, after notice and an  
21 opportunity for a hearing, may disapprove the  
22 continued use by a small employer carrier of a rider if  
23 the rider does not meet the requirements of this  
24 chapter and other applicable statutes.

25 Revised Law

26 Sec. 1501.260. PLAIN LANGUAGE REQUIRED. (a) A health  
27 benefit plan issuer may not issue and the commissioner may not  
28 approve a health benefit plan certificate or policy or a rider to a  
29 health benefit plan certificate or policy unless it is written in  
30 plain language.

31 (b) Each provision of a health benefit plan certificate or  
32 policy or a rider to a health benefit plan certificate or policy  
33 relating to renewal of coverage, conditions of coverage, or per  
34 occurrence or aggregate dollar limitations on coverage must be  
35 clearly explained in plain language.

36 (c) A health benefit plan issuer may not use and the  
37 commissioner may not approve a health benefit plan application form  
38 unless it is written in plain language.

39 (d) Subsections (a)-(c) do not apply if the specific  
40 language to be used is required by federal law or state statute or

1 by rules implementing federal law.

2 (e) For purposes of Subsections (a)-(d), a health benefit  
3 plan certificate or policy, a rider to or a provision of a health  
4 benefit plan certificate or policy, or a health benefit plan  
5 application form is written in plain language if it achieves the  
6 minimum score established by the commissioner on the Flesch reading  
7 ease test or an equivalent test selected by the commissioner.

8 (f) This section does not apply to:

9 (1) a health benefit plan group master policy; or

10 (2) a policy application or enrollment form for a  
11 health benefit plan group master policy. (V.T.I.C. Art. 26.43,  
12 Subsecs. (b), (c), (d), (e), (f), (g).)

13 Source Law

14 (b) A health carrier may not issue and the  
15 commissioner may not approve a health benefit plan  
16 certificate or policy or a rider to a health benefit  
17 plan certificate or policy unless it is written in  
18 plain language.

19 (c) Each provision of a health benefit plan  
20 certificate or policy or a rider to a health benefit  
21 plan certificate or policy relating to renewal of  
22 coverage, conditions of coverage, or per occurrence or  
23 aggregate dollar limitations on coverage must be  
24 clearly explained in plain language.

25 (d) A health carrier may not use and the  
26 commissioner may not approve a health benefit plan  
27 application form unless it is in plain language.

28 (e) Subsections (b) through (d) of this article  
29 do not apply if the specific language to be used is  
30 mandated by federal law or state statute or by rules  
31 implementing federal law.

32 (f) For purposes of Subsections (b) through (e)  
33 of this article, a health benefit plan certificate or  
34 policy, a rider to or a provision of a health benefit  
35 plan certificate or policy, or a health benefit plan  
36 application form is written in plain language if it  
37 achieves the minimum score established by the  
38 commissioner on the Flesch reading ease test or an  
39 equivalent test selected by the commissioner.

40 (g) The provisions of Subsections (b) through  
41 (f) of this article requiring the use of plain language  
42 do not apply to a health benefit plan group master  
43 policy or to a policy application or enrollment form  
44 for a health benefit plan group master policy.

45 [Sections 1501.261-1501.300 reserved for expansion]

46 SUBCHAPTER G. REINSURANCE FOR SMALL EMPLOYER HEALTH BENEFIT PLANS

47 Revised Law

48 Sec. 1501.301. DEFINITIONS. In this subchapter:

49 (1) "Board" means the board of directors of the Texas

1 Health Reinsurance System.

2 (2) "Plan of operation" means the plan of operation of  
3 the system established under Section 1501.306.

4 (3) "Reinsured health benefit plan issuer" means a  
5 small employer health benefit plan issuer that participates in the  
6 system.

7 (4) "Risk-assuming health benefit plan issuer" means a  
8 small employer health benefit plan issuer that does not participate  
9 in the system.

10 (5) "System" means the Texas Health Reinsurance System  
11 established under this subchapter. (V.T.I.C. Art. 26.02, Subdivs.  
12 (4), (22), (27); Art. 26.02, Subdiv. (33), as amended Acts 77th  
13 Leg., R.S., Ch. 823; Art. 26.02, Subdivs. (28), (32), as amended  
14 Acts 77th Leg., R.S., Ch. 608.)

15 Source Law

16 Art. 26.02. In this chapter:

17 (4) "Board of directors" means the board  
18 of directors of the Texas Health Reinsurance System.

19 (22) "Plan of operation" means the plan of  
20 operation of the system established under Article  
21 26.55 of this code.

22 (27) "Reinsured carrier" means a small  
23 employer carrier participating in the system.

24 Art. 26.02. [as amended Acts 77th Leg., R.S., Ch.  
25 823] In this chapter:

26 (33) "System" means the Texas Health  
27 Reinsurance System established under Subchapter F of  
28 this chapter.

29 Art. 26.02. [as amended Acts 77th Leg., R.S., Ch.  
30 608] In this chapter:

31 (28) "Risk-assuming carrier" means a small  
32 employer carrier that elects not to participate in the  
33 system.

34 (32) "System" means the Texas Health  
35 Reinsurance System established under Subchapter F of  
36 this chapter.

37 Revisor's Note

38 Subdivision (27), V.T.I.C. Article 26.02,  
39 defines "reinsured carrier." Subdivision (28),  
40 V.T.I.C. Article 26.02, as amended by Chapter 608,

1 Acts of the 77th Legislature, Regular Session, 2001,  
2 defines "risk-assuming carrier." Throughout this  
3 subchapter, the revised law substitutes "reinsured  
4 health benefit plan issuer" for "reinsured carrier"  
5 and "risk-assuming health benefit plan issuer" for  
6 "risk-assuming carrier" for the reason stated in  
7 Revisor's Note (4) to Section 1501.002.

8 Revised Law

9 Sec. 1501.302. TEXAS HEALTH REINSURANCE SYSTEM. The Texas  
10 Health Reinsurance System is a nonprofit entity administered by a  
11 board of directors and subject to the supervision and control of the  
12 commissioner. (V.T.I.C. Art. 26.53.)

13 Source Law

14 Art. 26.53. (a) The Texas Health Reinsurance  
15 System is created as a nonprofit entity.

16 (b) The system is administered by a board of  
17 directors and operates subject to the supervision and  
18 control of the commissioner.

19 Revisor's Note

20 Subsection (a), V.T.I.C. Article 26.53, provides  
21 that the Texas Health Reinsurance System "is created."  
22 The revised law omits the reference to the creation of  
23 the system because it has been executed.

24 Revised Law

25 Sec. 1501.303. SYSTEM BOARD OF DIRECTORS. (a) The board  
26 of directors of the system is composed of:

27 (1) nine members appointed by the commissioner; and

28 (2) the commissioner or the commissioner's  
29 representative, who serves as an ex officio member.

30 (b) Five of the appointed members must be representatives of  
31 reinsured health benefit plan issuers selected from individuals  
32 nominated by small employer health benefit plan issuers in this  
33 state according to procedures developed by the commissioner.

34 (c) Four of the appointed members must represent the public.  
35 A member representing the public may not:

36 (1) be an officer, director, or employee of an

1 insurance company, agency, agent, broker, solicitor, or adjuster or  
2 any other business entity regulated by the department;

3 (2) be a person required to register under Chapter  
4 305, Government Code; or

5 (3) be related to a person described by Subdivision  
6 (1) or (2) within the second degree by affinity or consanguinity.

7 (d) Appointed members serve two-year terms expiring  
8 December 31 of each odd-numbered year. A member's term continues  
9 until a successor is appointed.

10 (e) A member of the board may not be compensated for serving  
11 on the board but is entitled to reimbursement for actual expenses  
12 incurred in performing functions as a member of the board as  
13 provided by the General Appropriations Act. (V.T.I.C. Art. 26.54,  
14 Subsecs. (a), (b), (c).)

15 Source Law

16 Art. 26.54. (a) The board of directors is  
17 composed of nine members appointed by the  
18 commissioner. The commissioner or the commissioner's  
19 representative shall serve as an ex officio member.  
20 Five members must be representatives of reinsured  
21 carriers selected from individuals nominated by small  
22 employer carriers in this state according to  
23 procedures developed by the commissioner. Four  
24 members must represent the general public. A member  
25 representing the general public may not be:

26 (1) an officer, director, or employee of  
27 an insurance company, agency, agent, broker,  
28 solicitor, or adjuster or any other business entity  
29 regulated by the department;

30 (2) a person required to register with the  
31 Texas Ethics Commission under Chapter 305, Government  
32 Code; or

33 (3) related to a person described by  
34 Subdivision (1) or (2) of this subsection within the  
35 second degree of affinity or consanguinity.

36 (b) The members appointed by the commissioner  
37 serve two-year terms. The terms expire on December 31  
38 of each odd-numbered year. A member's term continues  
39 until a successor is appointed.

40 (c) A member of the board of directors may not be  
41 compensated for serving on the board of directors but  
42 is entitled to reimbursement for actual expenses  
43 incurred in performing functions as a member of the  
44 board of trustees as provided in the General  
45 Appropriations Act.

46 Revisor's Note

47 Subsection (a)(2), V.T.I.C. Article 26.54,  
48 refers to registration "with the Texas Ethics

Commission under Chapter 305, Government Code." The revised law omits the reference to the Texas Ethics Commission as unnecessary. Chapter 305, Government Code, provides for registration only with that agency.

Revised Law

Sec. 1501.304. OPEN MEETINGS; PUBLIC INFORMATION. The board is subject to:

(1) the open meetings law, Chapter 551, Government Code; and

(2) the public information law, Chapter 552, Government Code. (V.T.I.C. Art. 26.54, Subsec. (d).)

Source Law

(d) The board of directors is subject to the open meetings law, Chapter 271, Acts of the 60th Legislature, Regular Session, 1967 (Article 6252-17, Vernon's Texas Civil Statutes), and the open records law, Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-17a, Vernon's Texas Civil Statutes).

Revisor's Note

(1) Subsection (d), V.T.I.C. Article 26.54, refers to "the open meetings law, Chapter 271, Acts of the 60th Legislature, Regular Session, 1967 (Article 6252-17, Vernon's Texas Civil Statutes)." That statute was codified in 1993 as Chapter 551, Government Code. The revised law is drafted accordingly.

(2) Subsection (d), V.T.I.C. Article 26.54, refers to "the open records law, Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-17a, Vernon's Texas Civil Statutes)." The revised law substitutes a reference to the public information law, Chapter 552, Government Code, for the reason stated in the revisor's note to Section 1501.055.

Revised Law

Sec. 1501.305. BOARD MEMBER IMMUNITY. (a) A member of the

1 board is not liable for an act performed, or omission made, in good  
2 faith in the performance of powers and duties under this  
3 subchapter.

4 (b) A cause of action does not arise against a member of the  
5 board for an act or omission described by Subsection (a). (V.T.I.C.  
6 Art. 26.54, Subsec. (e).)

7 Source Law

8 (e) There is no liability on the part of, and no  
9 cause of action of any nature arises against, a member  
10 of the board of directors for action or omission  
11 performed in good faith in the performance of powers  
12 and duties under this subchapter.

13 Revised Law

14 Sec. 1501.306. SYSTEM PLAN OF OPERATION. (a) The board  
15 shall submit to the commissioner a plan of operation and any  
16 amendments to that plan necessary or suitable to ensure the fair,  
17 reasonable, and equitable administration of the system.

18 (b) The commissioner, after notice and hearing, may approve  
19 the plan of operation if the commissioner determines the plan:

20 (1) is suitable to ensure the fair, reasonable, and  
21 equitable administration of the system; and

22 (2) provides for the sharing of system gains or losses  
23 on an equitable and proportionate basis in accordance with this  
24 subchapter.

25 (c) The plan of operation is effective on the written  
26 approval of the commissioner.

27 (d) The plan of operation must:

28 (1) establish procedures for:

29 (A) handling and accounting for system assets and  
30 money;

31 (B) making an annual fiscal report to the  
32 commissioner;

33 (C) selecting an administering health benefit  
34 plan issuer or third-party administrator and establishing the  
35 powers and duties of the administering issuer or third-party  
36 administrator;

1 (D) reinsuring risks in accordance with this  
2 subchapter; and

3 (E) collecting assessments from reinsured health  
4 benefit plan issuers to fund claims and administrative expenses  
5 incurred or estimated to be incurred by the system, including the  
6 imposition of penalties for late payment of an assessment; and

7 (2) provide for any additional matter necessary to  
8 implement and administer the system. (V.T.I.C. Art. 26.55,  
9 Subsecs. (a) (part), (c).)

10 Source Law

11 Art. 26.55. (a) . . . the board of directors  
12 shall submit to the commissioner a plan of operation  
13 and thereafter any amendments necessary or suitable to  
14 ensure the fair, reasonable, and equitable  
15 administration of the system. The commissioner, after  
16 notice and hearing, may approve the plan of operation  
17 if the commissioner determines the plan is suitable to  
18 ensure the fair, reasonable, and equitable  
19 administration of the system and provides for the  
20 sharing of system gains or losses on an equitable and  
21 proportionate basis in accordance with the provisions  
22 of this subchapter. The plan of operation is effective  
23 on the written approval of the commissioner.

24 (c) The plan of operation must:

25 (1) establish procedures for the handling  
26 and accounting of system assets and money and for an  
27 annual fiscal report to the commissioner;

28 (2) establish procedures for the selection  
29 of an administering carrier or third-party  
30 administrator and establish the powers and duties of  
31 that administering carrier or third-party  
32 administrator;

33 (3) establish procedures for reinsuring  
34 risks in accordance with the provisions of this  
35 article;

36 (4) establish procedures for collecting  
37 assessments from reinsured carriers to fund claims and  
38 administrative expenses incurred or estimated to be  
39 incurred by the system, including the imposition of  
40 penalties for late payment of an assessment; and

41 (5) provide for any additional matters  
42 necessary for the implementation and administration of  
43 the system.

44 Revisor's Note

45 Subsection (a), V.T.I.C. Article 26.55, in part  
46 requires the board of directors of the Texas Health  
47 Reinsurance System to submit a plan of operation for  
48 the system to the commissioner of insurance "[n]ot  
49 later than the 180th day after the date on which a

1 majority of the members of the board of directors have  
2 been appointed." The revised law omits this provision  
3 as executed; it is a transition provision that applies  
4 only to the initial board. V.T.I.C. Articles  
5 26.51-26.62, revised as this subchapter, were enacted  
6 in 1993. Although Subsection (b), V.T.I.C. Article  
7 26.54, revised as Section 1501.303(d), provides that  
8 appointed members of the board of directors serve  
9 two-year terms that expire December 31 of each  
10 odd-numbered year, it also provides that a member's  
11 term continues until a successor is appointed. Thus,  
12 after the appointment of a majority of the initial  
13 members, there will always be "a majority of members"  
14 serving on the board.

15 Subsection (b), V.T.I.C. Article 26.55, provides  
16 that if the board of directors "fails to timely submit  
17 a suitable plan of operation, the commissioner, after  
18 notice and hearing, shall adopt a temporary plan of  
19 operation." Again, this is a transition provision  
20 that applies only to the initial board, and the revised  
21 law omits it as executed.

22 The omitted law reads:

23 Art. 26.55. (a) Not later than the  
24 180th day after the date on which a majority  
25 of the members of the board of directors  
26 have been appointed, [the board of  
27 directors shall submit to the commissioner  
28 a plan of operation] . . . .

29 (b) If the board of directors fails  
30 to timely submit a suitable plan of  
31 operation, the commissioner, after notice  
32 and hearing, shall adopt a temporary plan of  
33 operation. The commissioner shall amend or  
34 rescind any plan adopted under this  
35 subsection at the time a plan of operation  
36 is submitted by the board of directors and  
37 approved by the commissioner.

38 Revised Law

39 Sec. 1501.307. SYSTEM POWERS. (a) The system has the  
40 general powers and authority granted under state law to an insurer  
41 or a health maintenance organization authorized to engage in

1 business, except that the system may not directly issue a health  
2 benefit plan.

3 (b) The system may:

4 (1) enter into contracts necessary or proper to  
5 implement this subchapter, including, with the commissioner's  
6 approval, contracts with similar programs of other states for the  
7 joint performance of common functions or with persons or other  
8 organizations for the performance of administrative functions;

9 (2) sue or be sued, including taking legal action  
10 necessary or proper to recover assessments and penalties for, on  
11 behalf of, or against the system or a reinsured health benefit plan  
12 issuer;

13 (3) take legal action necessary to avoid the payment  
14 of improper claims against the system;

15 (4) issue reinsurance contracts in accordance with  
16 this subchapter;

17 (5) establish guidelines, conditions, and procedures  
18 for reinsuring risks under the plan of operation;

19 (6) establish actuarial functions as appropriate for  
20 the operation of the system;

21 (7) assess reinsured health benefit plan issuers in  
22 accordance with Sections 1501.319-1501.323;

23 (8) appoint appropriate legal, actuarial, and other  
24 committees necessary to provide technical assistance in:

25 (A) the operation of the system;

26 (B) policy and other contract design; and

27 (C) any other function within the authority of  
28 the system; and

29 (9) borrow money for a period not to exceed one year to  
30 accomplish the purposes of the system.

31 (c) The system is exempt from all taxes. (V.T.I.C. Art.  
32 26.56 (part).)

33 Source Law

34 Art. 26.56. The system has the general powers

1 and authority granted under the laws of this state to  
2 insurance companies and health maintenance  
3 organizations licensed to transact business, except  
4 that the system may not directly issue health benefit  
5 plans. The system is exempt from all taxes. The  
6 system may:

7 (1) enter into contracts necessary or  
8 proper to carry out the provisions and purposes of this  
9 subchapter and may, with the approval of the  
10 commissioner, enter into contracts with similar  
11 programs of other states for the joint performance of  
12 common functions or with persons or other  
13 organizations for the performance of administrative  
14 functions;

15 (2) sue or be sued, including taking legal  
16 actions necessary or proper to recover assessments and  
17 penalties for, on behalf of, or against the system or a  
18 reinsured carrier;

19 (3) take legal action necessary to avoid  
20 the payment of improper claims against the system;

21 (4) issue reinsurance contracts in  
22 accordance with the requirements of this subchapter;

23 (5) establish guidelines, conditions, and  
24 procedures for reinsuring risks under the plan of  
25 operation;

26 (6) establish actuarial functions as  
27 appropriate for the operation of the system;

28 (7) assess reinsured carriers in  
29 accordance with the provisions of Article 26.60 of  
30 this code and . . . ;

31 (8) appoint appropriate legal, actuarial,  
32 and other committees as necessary to provide technical  
33 assistance in the operation of the system, policy and  
34 other contract design, and any other function within  
35 the authority of the system; and

36 (9) borrow money for a period not to exceed  
37 one year to effect the purposes of the system, provided  
38 that . . . .

#### 39 Revisor's Note

40 V.T.I.C. Article 26.56 refers to "insurance  
41 companies and health maintenance organizations  
42 licensed to transact business." The revised law  
43 substitutes "authorized to engage in business" for the  
44 quoted language for consistency with other terminology  
45 used throughout this code.

#### 46 Revised Law

47 Sec. 1501.308. SYSTEM NOTES AS LEGAL INVESTMENT FOR SMALL  
48 EMPLOYER HEALTH BENEFIT PLAN ISSUER. A note or other evidence of  
49 indebtedness of the system that is not in default is a legal  
50 investment for a small employer health benefit plan issuer and may  
51 be carried as an admitted asset. (V.T.I.C. Art. 26.56 (part).)

#### 52 Source Law

53 Art. 26.56. . . .

1                   (9) . . . any notes or other evidence of  
2 indebtedness of the system not in default shall be  
3 legal investments for small employer carriers and may  
4 be carried as admitted assets.

5                               Revised Law

6           Sec. 1501.309. SYSTEM AUDIT. (a) The transactions of the  
7 system are subject to audit by the state auditor in accordance with  
8 Chapter 321, Government Code.

9           (b) The state auditor shall report the cost of each audit  
10 conducted under this section to the board and the comptroller, and  
11 the board shall remit that amount to the comptroller. (V.T.I.C.  
12 Art. 26.57.)

13                               Source Law

14           Art. 26.57. (a) The transactions of the system  
15 are subject to audit by the state auditor in accordance  
16 with Chapter 321, Government Code.

17           (b) The state auditor shall report the cost of  
18 each audit conducted under this article to the board of  
19 directors and the comptroller, and the board of  
20 directors shall remit that amount to the comptroller  
21 for deposit to the general revenue fund.

22                               Revisor's Note

23           Subsection (b), V.T.I.C. Article 26.57, provides  
24 that the board of directors shall remit a specified  
25 amount to the comptroller "for deposit to the general  
26 revenue fund." The revised law omits the quoted  
27 language as unnecessary. Section 404.094, Government  
28 Code (State Funds Reform Act), requires all money,  
29 including the referenced amount, collected or received  
30 by a state agency to be deposited to the credit of the  
31 general revenue fund if another fund or account is not  
32 specified in the law authorizing the collection or  
33 receipt. It is unnecessary to repeat that requirement  
34 in this chapter.

35                               Revised Law

36           Sec. 1501.310. ELECTION OF STATUS. (a) Each small employer  
37 health benefit plan issuer shall notify the commissioner of the  
38 issuer's election to operate as a risk-assuming health benefit plan  
39 issuer or as a reinsured health benefit plan issuer. An issuer that

1 elects to operate as a risk-assuming health benefit plan issuer  
2 shall file an application in accordance with Section 1501.312.

3 (b) A small employer health benefit plan issuer's election  
4 under this section is effective until the fifth anniversary of the  
5 date of the election.

6 (c) The commissioner may permit a small employer health  
7 benefit plan issuer to modify its election at any time for good  
8 cause shown. (V.T.I.C. Art. 26.51, Subsecs. (a), (b).)

9 Source Law

10 Art. 26.51. (a) Each small employer carrier  
11 shall notify the commissioner of the carrier's  
12 election to operate as a risk-assuming carrier or a  
13 reinsured carrier. A small employer carrier seeking  
14 to operate as a risk-assuming carrier shall make an  
15 application under Article 26.52 of this code.

16 (b) A small employer carrier's election under  
17 Subsection (a) of this article is effective until the  
18 fifth anniversary of the election. The commissioner  
19 may permit a small employer carrier to modify its  
20 decision at any time for good cause shown.

21 Revised Law

22 Sec. 1501.311. CHANGE IN STATUS. (a) The commissioner  
23 shall establish an application process for a small employer health  
24 benefit plan issuer that elects to change its status under this  
25 subchapter.

26 (b) A reinsured health benefit plan issuer that elects to  
27 change its status to operate as a risk-assuming health benefit plan  
28 issuer may not continue to reinsure a small employer health benefit  
29 plan with the system. The issuer shall pay a prorated assessment  
30 based on business issued as a reinsured health benefit plan issuer  
31 for the portion of the year the business was reinsured. (V.T.I.C.  
32 Art. 26.51, Subsecs. (c), (d).)

33 Source Law

34 (c) The commissioner shall establish an  
35 application process for small employer carriers  
36 seeking to change their status under this article.

37 (d) A reinsured carrier that elects to change  
38 its status to operate as a risk-assuming carrier may  
39 not continue to reinsure a small employer health  
40 benefit plan with the system. The carrier shall pay a  
41 prorated assessment based on business issued as a  
42 reinsured carrier for any portion of the year that the  
43 business was reinsured.



1 decision on the application. If the application is not  
2 acted on before the 90th day after the date the  
3 commissioner received the application, the carrier may  
4 request and the commissioner shall grant a hearing.

5 Revised Law

6 Sec. 1501.313. RESCISSION OF APPROVAL TO OPERATE AS  
7 RISK-ASSUMING HEALTH BENEFIT PLAN ISSUER. The commissioner, after  
8 notice and hearing, may rescind approval to operate as a  
9 risk-assuming health benefit plan issuer if the commissioner finds  
10 that the issuer:

11 (1) is not financially able to support the assumption  
12 of risk from issuing coverage to small employers without the  
13 protection provided by the system;

14 (2) has failed to market fairly to all small employers  
15 in the state or in the issuer's established geographic service  
16 area; or

17 (3) has failed to provide coverage to eligible small  
18 employers. (V.T.I.C. Art. 26.52, Subsec. (d).)

19 Source Law

20 (d) The commissioner, after notice and hearing,  
21 may rescind the approval granted to a risk-assuming  
22 carrier under this article if the commissioner finds  
23 that the carrier:

24 (1) is not financially able to support the  
25 assumption of risk from issuing coverage to small  
26 employers without the protection afforded by the  
27 system;

28 (2) has failed to market fairly to all  
29 small employers in the state or its established  
30 geographic service area; or

31 (3) has failed to provide coverage to  
32 eligible small employers.

33 Revised Law

34 Sec. 1501.314. REINSURANCE. (a) A small employer health  
35 benefit plan issuer may reinsure risks covered under a small  
36 employer health benefit plan with the system as provided by this  
37 subchapter.

38 (b) The system shall reinsure the level of coverage provided  
39 under the small employer health benefit plan.

40 (c) A small employer health benefit plan issuer may  
41 reinsure:

42 (1) an entire small employer group not later than the

1 60th day after the date the group's coverage under the small  
2 employer health benefit plan takes effect;

3 (2) an eligible employee of a small employer or the  
4 employee's dependent not later than the 60th day after the date the  
5 person's coverage takes effect; or

6 (3) a newly eligible employee of a reinsured small  
7 employer group, the employee's dependent, or an individual covered  
8 under the small employer health benefit plan not later than the 60th  
9 day after the date the individual's coverage takes effect.

10 (V.T.I.C. Art. 26.58, Subsecs. (a), (b), (c).)

11 Source Law

12 Art. 26.58. (a) A small employer carrier may  
13 reinsure risks covered under the small employer health  
14 benefit plans with the system as provided by this  
15 article.

16 (b) The system shall reinsure the level of  
17 coverage provided under the small employer health  
18 benefit plans.

19 (c) A small employer carrier may reinsure an  
20 entire small employer group not later than the 60th day  
21 after the date on which the group's coverage under the  
22 small employer health benefit plans takes effect. A  
23 small employer carrier may reinsure an eligible  
24 employee of a small employer or the employee's  
25 dependent not later than the 60th day after the date on  
26 which that individual's coverage takes effect. A newly  
27 eligible employee or dependent of a reinsured small  
28 employer group or an individual covered under the  
29 small employer health benefit plans may be reinsured  
30 not later than the 60th day after the date on which  
31 that individual's coverage takes effect.

32 Revised Law

33 Sec. 1501.315. LIMITS ON REINSURANCE. (a) The system may  
34 not reimburse a reinsured health benefit plan issuer for the claims  
35 of a reinsured individual until the issuer has incurred an initial  
36 level of claims of \$5,000 in a calendar year for that individual for  
37 benefits covered by the system. In addition, the reinsured health  
38 benefit plan issuer is responsible for 10 percent of the next  
39 \$50,000 of benefit payments during a calendar year, and the system  
40 shall reinsure the remainder. A reinsured health benefit plan  
41 issuer's liability to a reinsured individual may not exceed a  
42 maximum of \$10,000 in a calendar year.

43 (b) The board annually shall adjust the initial level of

1 claims and the maximum liability to be retained by a reinsured  
2 health benefit plan issuer under Subsection (a) to reflect  
3 increases in:

4 (1) costs; and

5 (2) the use of small employer health benefit plans in  
6 this state.

7 (c) An adjustment under Subsection (b) may not be less than  
8 the annual change in the medical component of the Consumer Price  
9 Index for All Urban Consumers published by the Bureau of Labor  
10 Statistics of the United States Department of Labor unless the  
11 board proposes and the commissioner approves a lower adjustment  
12 factor. (V.T.I.C. Art. 26.58, Subsecs. (d), (e).)

13 Source Law

14 (d) The system may not reimburse a reinsured  
15 carrier for the claims of any reinsured individual  
16 until the carrier has incurred an initial level of  
17 claims for that individual in a calendar year of \$5,000  
18 for benefits covered by the system. In addition, the  
19 reinsured carrier is responsible for 10 percent of the  
20 next \$50,000 of benefit payments during a calendar  
21 year, and the system shall reinsure the remainder. A  
22 reinsured carrier's liability to any insured  
23 individual may not exceed a maximum of \$10,000 in any  
24 one calendar year for that individual.

25 (e) The board of directors annually shall adjust  
26 the initial level of claims and the maximum to be  
27 retained by the carrier established under Subsection  
28 (d) of this article to reflect increases in costs and  
29 in use for small employer health benefit plans in this  
30 state. The adjustment may not be less than the annual  
31 change in the medical component of the Consumer Price  
32 Index for All Urban Consumers published by the Bureau  
33 of Labor Statistics of the United States Department of  
34 Labor unless the board of directors proposes and the  
35 commissioner approves a lower adjustment factor.

36 Revised Law

37 Sec. 1501.316. TERMINATION OF REINSURANCE. A small  
38 employer health benefit plan issuer may terminate reinsurance with  
39 the system for one or more reinsured employees or dependents of  
40 employees of a small employer on a contract anniversary of the small  
41 employer health benefit plan. (V.T.I.C. Art. 26.58, Subsec. (f).)

42 Source Law

43 (f) A small employer carrier may terminate  
44 reinsurance with the system for one or more of the  
45 reinsured employees or dependents of employees of a  
46 small employer on a contract anniversary of the small

1 employer health benefit plans.

2 Revised Law

3 Sec. 1501.317. APPLICATION OF MANAGED CARE PROCEDURES.

4 Except as provided by the plan of operation, a reinsured health  
5 benefit plan issuer shall apply consistently with respect to  
6 reinsured and nonreinsured business all managed care procedures,  
7 including utilization review, individual case management,  
8 preferred provider provisions, and other managed care provisions or  
9 methods of operation. (V.T.I.C. Art. 26.58, Subsec. (g).)

10 Source Law

11 (g) Except as provided in the plan of operation,  
12 a reinsured carrier shall apply consistently with  
13 respect to reinsured and nonreinsured business all  
14 managed care procedures, including utilization  
15 review, individual case management, preferred  
16 provider provisions, and other managed care provisions  
17 or methods of operation.

18 Revised Law

19 Sec. 1501.318. PREMIUM RATES FOR REINSURANCE. (a) As part  
20 of the plan of operation, the board shall adopt a method to  
21 determine premium rates to be charged by the system for reinsuring  
22 small employer groups and individuals under this subchapter.

23 (b) The method adopted must:

24 (1) include a classification system for small employer  
25 groups that reflects the variations in premium rates allowed by  
26 this chapter; and

27 (2) provide for the development of base reinsurance  
28 premium rates that reflect the allowable variations.

29 (c) Subject to approval by the commissioner, the board shall  
30 establish the base reinsurance premium rates at levels that  
31 reasonably approximate the gross premiums charged to small  
32 employers by small employer health benefit plan issuers for small  
33 employer health benefit plans, adjusted to reflect retention levels  
34 required under this subchapter.

35 (d) The board shall periodically review the method adopted  
36 under this section, including the classification system and any  
37 rating factors, to ensure that the method reasonably reflects the

1 claims experience of the system. The board may propose changes to  
2 the method. Any changes are subject to approval by the  
3 commissioner.

4 (e) An entire small employer group may be reinsured at a  
5 rate that is 1-1/2 times the base reinsurance premium rate for that  
6 group. An eligible employee of a small employer or the employee's  
7 dependent covered under a small employer health benefit plan may be  
8 reinsured at a rate that is five times the base reinsurance premium  
9 rate for that individual.

10 (f) The board may consider adjustments to the premium rates  
11 charged by the system to reflect the use of effective cost  
12 containment and managed care arrangements. (V.T.I.C. Art. 26.59.)

13 Source Law

14 Art. 26.59. (a) As part of the plan of  
15 operation, the board of directors shall adopt a method  
16 to determine premium rates to be charged by the system  
17 for reinsuring small employer groups and individuals  
18 under this subchapter.

19 (b) The method adopted must include  
20 classification systems for small employer groups that  
21 reflect the variations in premium rates allowed in  
22 this chapter and must provide for the development of  
23 base reinsurance premium rates that reflect the  
24 allowable variations. The base reinsurance premium  
25 rates shall be established by the board of directors,  
26 subject to the approval of the board, and shall be set  
27 at levels that reasonably approximate the gross  
28 premiums charged to small employers by small employer  
29 carriers for the small employer health benefit plans,  
30 adjusted to reflect retention levels required under  
31 this subchapter. The board of directors periodically  
32 shall review the method adopted under this subsection,  
33 including the classification system and any rating  
34 factors, to ensure that the method reasonably reflects  
35 the claim experience of the system. The board of  
36 directors may propose changes to the method. The  
37 changes are subject to the approval of the board.

38 (c) An entire small employer group may be  
39 reinsured at a rate that is 1 1/2 times the base  
40 reinsurance premium rate for that group. An eligible  
41 employee of a small employer or the employee's  
42 dependent covered under the small employer health  
43 benefit plans may be reinsured at a rate that is five  
44 times the base reinsurance premium rate for that  
45 individual.

46 (d) The board of directors may consider  
47 adjustments to the premium rates charged by the system  
48 to reflect the use of effective cost containment and  
49 managed care arrangements.

50 Revisor's Note

51 Subsection (b), V.T.I.C. Article 26.59, provides

1       that the base reinsurance premium rates under the  
2       Texas Health Reinsurance System "shall be established  
3       by the board of directors, subject to the approval of  
4       the board," and that "[t]he board of directors may  
5       propose changes to the method [of determining premium  
6       rates,] . . . subject to the approval of the board."  
7       The references to the "board" that may approve premium  
8       rates and changes to the method of determining rates  
9       are references to the State Board of Insurance.  
10      Accordingly, the revised law substitutes references to  
11      the commissioner for the reason stated in Revisor's  
12      Note (1) to Section 1501.211.

13                               Revised Law

14      Sec. 1501.319. DETERMINATION OF NET LOSS. (a) Not later  
15      than March 1 of each year, the board shall determine the system's  
16      net loss for the preceding calendar year, including administrative  
17      expenses and incurred losses for the year, and report the net loss  
18      to the commissioner.

19      (b) In determining the net loss, the board shall take into  
20      account investment income and other appropriate gains and losses.  
21      (V.T.I.C. Art. 26.60, Subsec. (a) (part).)

22                               Source Law

23      Art. 26.60. (a) Not later than March 1 of each  
24      year, the board of directors shall determine and  
25      report to the commissioner the system net loss for the  
26      previous calendar year, including administrative  
27      expenses and incurred losses for the year, taking into  
28      account investment income and other appropriate gains  
29      and losses. . . .

30                               Revised Law

31      Sec. 1501.320. ASSESSMENTS TO RECOVER NET LOSSES. (a) The  
32      board shall recover any net loss of the system by assessing each  
33      reinsured health benefit plan issuer an amount determined annually  
34      by the board based on information in annual statements and other  
35      reports required by and filed with the board.

36      (b) The board shall establish, as part of the plan of  
37      operation, a formula by which to make assessments against reinsured

1 health benefit plan issuers. With the approval of the  
2 commissioner, the board may periodically change the assessment  
3 formula as appropriate. The board shall base the assessment  
4 formula on each reinsured issuer's share of:

5 (1) the total premiums earned in the preceding  
6 calendar year from small employer health benefit plans delivered or  
7 issued for delivery by reinsured health benefit plan issuers to  
8 small employer groups in this state; and

9 (2) the premiums earned in the preceding calendar year  
10 from newly issued small employer health benefit plans delivered or  
11 issued for delivery during the calendar year by reinsured health  
12 benefit plan issuers to small employer groups in this state.

13 (V.T.I.C. Art. 26.60, Subsec. (a) (part).)

14 Source Law

15 (a) . . . Any net loss for the year must be  
16 recouped by assessments on reinsured carriers. Each  
17 reinsured carrier's assessment shall be determined  
18 annually by the board of directors based on annual  
19 statements and other reports required by the board of  
20 directors and filed with that board. The board of  
21 directors shall establish, as part of the plan of  
22 operation, a formula by which to make assessments  
23 against reinsured carriers. With the approval of the  
24 commissioner, the board of directors may change the  
25 assessment formula from time to time as appropriate.  
26 The board of directors shall base the assessment  
27 formula on each reinsured carrier's share of:

28 (1) the total premiums earned in the  
29 preceding calendar year from the small employer health  
30 benefit plans delivered or issued for delivery by  
31 reinsured carriers to small employer groups in this  
32 state; and

33 (2) the premiums earned in the preceding  
34 calendar year from newly issued small employer health  
35 benefit plans delivered or issued for delivery during  
36 the calendar year by reinsured carriers to small  
37 employer groups in this state.

38 Revised Law

39 Sec. 1501.321. LIMITS ON ASSESSMENTS. (a) The formula  
40 established under Section 1501.320(b) may not result in an  
41 assessment for a reinsured health benefit plan issuer that is less  
42 than 50 percent or more than 150 percent of an amount based on the  
43 proportion of the total premiums earned in the preceding calendar  
44 year from small employer health benefit plans delivered or issued  
45 for delivery to small employer groups in this state by that issuer

1 to the total premiums earned in the preceding calendar year from  
2 small employer health benefit plans delivered or issued for  
3 delivery to small employer groups in this state by all reinsured  
4 health benefit plan issuers.

5 (b) In determining assessments, the board may not consider  
6 premiums earned by a reinsured health benefit plan issuer that are  
7 less than an amount determined by the board to justify the cost of  
8 collecting an assessment based on those premiums. (V.T.I.C. Art.  
9 26.60, Subsec. (b).)

#### 10 Source Law

11 (b) The formula established under Subsection  
12 (a) of this article may not result in an assessment  
13 share for a reinsured carrier that is less than 50  
14 percent or more than 150 percent of an amount based on  
15 the proportion of the total premium earned in the  
16 preceding calendar year from the small employer health  
17 benefit plans delivered or issued for delivery to  
18 small employer groups in this state by that reinsured  
19 carrier to the total premiums earned in the preceding  
20 calendar year from small employer health benefit plans  
21 delivered or issued for delivery to small employer  
22 groups in this state by all reinsured carriers.  
23 Premiums earned by a reinsured carrier that are less  
24 than an amount determined by the board of directors to  
25 justify the cost of collection of an assessment based  
26 on those premiums may not be considered by the board of  
27 directors in determining assessments.

#### 28 Revised Law

29 Sec. 1501.322. ADJUSTMENT TO ASSESSMENTS ON FEDERALLY  
30 QUALIFIED HEALTH MAINTENANCE ORGANIZATIONS. With the  
31 commissioner's approval, the board may adjust the formula  
32 established under Section 1501.320(b) for a reinsured health  
33 benefit plan issuer that is an approved health maintenance  
34 organization that is federally qualified under Title XIII, Public  
35 Health Service Act (42 U.S.C. Section 300e et seq.), to the extent  
36 that any restriction is imposed on that issuer that is not imposed  
37 on other issuers. (V.T.I.C. Art. 26.60, Subsec. (c).)

#### 38 Source Law

39 (c) With the approval of the commissioner, the  
40 board of directors may adjust the assessment formula  
41 for reinsured carriers that are approved health  
42 maintenance organizations that are federally  
43 qualified under Subchapter XI, Public Health Service  
44 Act (42 U.S.C. Section 300e et seq.), to the extent  
45 that any restrictions are imposed on those health

1 maintenance organizations that are not imposed on  
2 other health carriers.

3 Revised Law

4 Sec. 1501.323. ADVANCE INTERIM ASSESSMENTS. (a) The  
5 system may make advance interim assessments as reasonable and  
6 necessary for organizational and interim operating expenses.

7 (b) After the end of the fiscal year, the system shall  
8 credit an interim assessment made under this section as an offset  
9 against regular assessments due. (V.T.I.C. Art. 26.56 (part).)

10 Source Law

11 Art. 26.56. . . . The system may:

12 . . .  
13 (7) . . . make advance interim  
14 assessments as may be reasonable and necessary for  
15 organizational and interim operating expenses,  
16 provided that any interim assessments shall be  
17 credited as offsets against regular assessments due  
18 after the close of the fiscal year;  
19 . . .

20 Revised Law

21 Sec. 1501.324. LIMIT ON TOTAL ASSESSMENTS. The maximum  
22 assessment amount payable for a calendar year may not exceed five  
23 percent of the total premiums earned in the preceding calendar year  
24 from small employer health benefit plans delivered or issued for  
25 delivery by reinsured health benefit plan issuers in this state.  
26 (V.T.I.C. Art. 26.61, Subsec. (f).)

27 Source Law

28 (f) The maximum assessment amount payable for a  
29 calendar year may not exceed five percent of the total  
30 premiums earned in the preceding calendar year from  
31 small employer health benefit plans delivered or  
32 issued for delivery by reinsured carriers in this  
33 state.

34 Revised Law

35 Sec. 1501.325. ESTIMATE OF ASSESSMENTS; EVALUATION AND  
36 PROTECTION OF SYSTEM. (a) Not later than March 1 of each year,  
37 the board shall file with the commissioner an estimate of the  
38 assessments necessary to fund the losses for small employer groups  
39 incurred by the system during the preceding calendar year.

40 (b) If the board determines that the necessary assessments  
41 exceed five percent of the total premiums earned in the preceding

1 calendar year from small employer health benefit plans delivered or  
2 issued for delivery by reinsured health benefit plan issuers to  
3 small employer groups in this state, the board shall evaluate the  
4 operation of the system and shall report its findings, including  
5 any recommendations for changes to the plan of operation, to the  
6 commissioner not later than April 1 of the year following the  
7 calendar year in which the losses were incurred. The evaluation  
8 must:

9 (1) include an estimate of future assessments; and

10 (2) consider:

11 (A) the administrative costs of the system;

12 (B) the appropriateness of the premiums charged;

13 (C) the level of health benefit plan issuer  
14 retention under the system; and

15 (D) the costs of coverage for small employer  
16 groups.

17 (c) If the board fails to timely file a report required by  
18 Subsection (b), the commissioner may:

19 (1) evaluate the operations of the system; and

20 (2) implement amendments to the plan of operation that  
21 the commissioner considers necessary to reduce future losses and  
22 assessments.

23 (d) A reinsured health benefit plan issuer may not write  
24 small employer health benefit plans on a guaranteed issue basis  
25 during a calendar year if the assessment amount payable for the  
26 preceding calendar year is at least five percent of the total  
27 premiums earned in that calendar year from small employer health  
28 benefit plans delivered or issued for delivery by reinsured health  
29 benefit plan issuers in this state.

30 (e) A reinsured health benefit plan issuer may not write  
31 small employer health benefit plans on a guaranteed issue basis  
32 after the board determines that the expected loss from the  
33 reinsurance system for a year will exceed the total amount of  
34 assessments payable at a rate of five percent of the total premiums

1 earned for the preceding calendar year. A reinsured health benefit  
2 plan issuer may not resume writing small employer health benefit  
3 plans on a guaranteed issue basis until the board determines that  
4 the expected loss will be less than the maximum established by this  
5 subsection. (V.T.I.C. Art. 26.61, Subsecs. (a), (b), (c), (d),  
6 (e).)

#### 7 Source Law

8 Art. 26.61. (a) Not later than March 1 of each  
9 year, the board of directors shall file with the  
10 commissioner an estimate of the assessments necessary  
11 to fund the losses for small employer groups incurred  
12 by the system during the previous calendar year.

13 (b) If the board of directors determines that  
14 the necessary assessments exceed five percent of the  
15 total premiums earned in the previous calendar year  
16 from small employer health benefit plans delivered or  
17 issued for delivery by reinsured carriers to small  
18 employer groups in this state, the board of directors  
19 shall evaluate the operation of the system and shall  
20 report its findings, including any recommendations for  
21 changes to the plan of operation, to the commissioner  
22 not later than April 1 of the year following the  
23 calendar year in which the losses were incurred. The  
24 evaluation must include an estimate of future  
25 assessments and must consider the administrative costs  
26 of the system, the appropriateness of the premiums  
27 charged, the level of insurer retention under the  
28 system, and the costs of coverage for small employer  
29 groups.

30 (c) If the board of directors fails to timely  
31 file a report, the commissioner may evaluate the  
32 operations of the system and may implement amendments  
33 to the plan of operation as considered necessary by the  
34 commissioner to reduce future losses and assessments.

35 (d) Reinsured carriers may not write small  
36 employer health benefit plans on a guaranteed issue  
37 basis during a calendar year if the assessment amount  
38 payable for the previous calendar year is at least five  
39 percent of the total premiums earned in that calendar  
40 year from small employer health benefit plans  
41 delivered or issued for delivery by reinsured carriers  
42 in this state.

43 (e) Reinsured carriers may not write small  
44 employer health benefit plans on a guaranteed issue  
45 basis after the board of directors determines that the  
46 expected loss from the reinsurance system for a year  
47 will exceed the total amount of assessments payable at  
48 a rate of five percent of the total premiums earned for  
49 the previous calendar year. Reinsured carriers may  
50 not resume writing small employer health benefit plans  
51 on a guaranteed issue basis until the board of  
52 directors determines that the expected loss will be  
53 less than the maximum established by this subsection.

#### 54 Revised Law

55 Sec. 1501.326. DEFERMENT OF ASSESSMENT. (a) A reinsured  
56 health benefit plan issuer may petition the commissioner for a

1     deferment in whole or in part of an assessment imposed by the board.

2             (b)   The commissioner may defer all or part of the assessment  
3     if the commissioner determines that payment of the assessment would  
4     endanger the ability of the reinsured health benefit plan issuer to  
5     fulfill its contractual obligations.

6             (c)   The board shall assess the amount of a deferred  
7     assessment against other reinsured health benefit plan issuers in a  
8     manner consistent with the basis for assessment established by this  
9     subchapter.

10            (d)   A reinsured health benefit plan issuer that receives a  
11    deferment:

12                (1)   is liable to the system for the amount deferred;  
13    and

14                (2)   until the issuer pays the outstanding assessment,  
15    may not:

16                    (A)   market, deliver, or issue for delivery a  
17    small employer health benefit plan; or

18                    (B)   reinsure any individual or group with the  
19    system. (V.T.I.C. Art. 26.62.)

20                                   Source Law

21             Art. 26.62. (a) A reinsured carrier may  
22    petition the commissioner for a deferment in whole or  
23    in part of an assessment imposed by the board of  
24    directors.

25             (b)   The commissioner may defer all or part of  
26    the assessment of a reinsured carrier if the  
27    commissioner determines that the payment of the  
28    assessment would endanger the ability of the reinsured  
29    carrier to fulfill its contractual obligations.

30             (c)   If an assessment against a reinsured carrier  
31    is deferred, the amount deferred shall be assessed  
32    against the other reinsured carriers in a manner  
33    consistent with the basis for assessment established  
34    by this subchapter.

35             (d)   A reinsured carrier receiving a deferment is  
36    liable to the system for the amount deferred and is  
37    prohibited from marketing, delivering, or issuing for  
38    delivery a small employer health benefit plan or  
39    reinsuring any individual or group with the system  
40    until it pays the outstanding assessment.

41             [Sections 1501.327-1501.350 reserved for expansion]

1 SUBCHAPTER H. MARKETING OF SMALL EMPLOYER HEALTH BENEFIT PLANS

2 Revised Law

3 Sec. 1501.351. MARKETING REQUIREMENTS. (a) Each small  
4 employer health benefit plan issuer shall market a small employer  
5 health benefit plan to eligible small employers in this state  
6 through properly licensed agents.

7 (b) Each small employer purchasing a small employer health  
8 benefit plan must be given a summary, in a format prescribed by the  
9 commissioner, of the health benefit plans established by the  
10 commissioner under Subchapter F.

11 (c) An agent shall offer and explain to a small employer on  
12 inquiry and request by the employer each health benefit plan  
13 established by the commissioner under Subchapter F. (V.T.I.C. Art.  
14 26.71, Subsec. (a).)

15 Source Law

16 Art. 26.71. (a) Each small employer carrier  
17 shall market the small employer health benefit plan  
18 through properly licensed agents to eligible small  
19 employers in this state. Each small employer  
20 purchasing a small employer health benefit plan shall  
21 be given a summary of the benefit plans established by  
22 the commissioner under Subchapter E of this chapter.  
23 The commissioner shall prescribe the format of the  
24 summary. The agent shall offer and explain each of the  
25 plans to the small employer on inquiry and request by  
26 the small employer.

27 Revised Law

28 Sec. 1501.352. HEALTH STATUS AND CLAIMS EXPERIENCE;  
29 PROHIBITED ACTS. (a) A small employer health benefit plan issuer  
30 or agent may not, because of the health status or claims experience  
31 of the eligible employees of a small employer and those employees'  
32 dependents, directly or indirectly encourage or direct the employer  
33 to:

34 (1) refrain from applying for coverage with the  
35 issuer;

36 (2) seek coverage from another issuer; or

37 (3) apply for a particular small employer health  
38 benefit plan.

39 (b) A small employer health benefit plan issuer may not

1 directly or indirectly enter into an agreement or arrangement with  
2 an agent that provides for or results in compensation paid to the  
3 agent for the sale of small employer health benefit plans that  
4 varies because of health status or claims experience.

5 (c) Subsection (b) does not apply to an arrangement that  
6 provides compensation to an agent based on a percentage of premium,  
7 except that the percentage may not vary because of health status or  
8 claims experience.

9 (d) A small employer health benefit plan issuer or agent may  
10 not encourage a small employer to exclude an eligible employee from  
11 health coverage provided in connection with the employee's  
12 employment.

13 (e) A small employer health benefit plan issuer may not  
14 terminate, fail to renew, or limit its contract or agreement of  
15 representation with an agent for a reason related to the health  
16 status or claims experience of a small employer group placed by the  
17 agent with the issuer. (V.T.I.C. Art. 26.72; Art. 26.73, Subsec.  
18 (b).)

19 Source Law

20 Art. 26.72. (a) A small employer carrier or  
21 agent may not, directly or indirectly:

22 (1) encourage or direct a small employer  
23 to refrain from applying for coverage with the small  
24 employer carrier because of health status or claim  
25 experience of the eligible employees and dependents of  
26 the small employer;

27 (2) encourage or direct a small employer  
28 to seek coverage from another health carrier because  
29 of health status or claim experience of the eligible  
30 employees and dependents of the small employer; or

31 (3) encourage or direct a small employer  
32 to apply for a particular small employer health  
33 benefit plan because of health status or claim  
34 experience of the eligible employees and dependents of  
35 the small employer.

36 (b) A small employer carrier may not, directly  
37 or indirectly, enter into an agreement or arrangement  
38 with an agent that provides for or results in the  
39 compensation paid to an agent for the sale of the small  
40 employer health benefit plans to be varied because of  
41 health status or claim experience.

42 (c) Subsection (b) of this article does not  
43 apply to an arrangement that provides compensation to  
44 an agent on the basis of percentage of premium,  
45 provided that the percentage may not vary because of  
46 health status or claim experience.

47 (d) A small employer carrier or agent may not  
48 encourage a small employer to exclude an eligible

1 employee from health coverage provided in connection  
2 with the employee's employment.

3 [Art. 26.73]

4 (b) A small employer carrier may not terminate,  
5 fail to renew, or limit its contract or agreement of  
6 representation with an agent for any reason related to  
7 the health status or claim experience of a small  
8 employer group placed by the agent with the carrier.

9 Revised Law

10 Sec. 1501.353. AGENT COMPENSATION. (a) A small employer  
11 health benefit plan issuer shall pay the same commission,  
12 percentage of premium, or other amount to an agent for renewal of a  
13 small employer health benefit plan as the issuer paid for original  
14 placement of the plan, except that the issuer may increase  
15 compensation for renewal of a plan to reflect an increase in the  
16 cost of living or similar factors.

17 (b) A small employer health benefit plan issuer may not  
18 implement, directly or indirectly, agent commission schedules that  
19 vary the level of agent commissions based on the size of the group  
20 or otherwise reduce access to small employer health benefit plans.

21 (c) Notwithstanding Subsection (b), a small employer health  
22 benefit plan issuer may:

23 (1) vary agent commission amounts or percentages  
24 based on group size if the variation in the commission amounts or  
25 percentages are inversely related to the size of the group;

26 (2) vary agent commission amounts or percentages based  
27 on the cumulative premium paid by a single small employer over a  
28 specific period if the variation in the commission amounts or  
29 percentages are inversely related to the cumulative premium paid  
30 during the period; or

31 (3) pay agent commissions as a percentage of premiums  
32 charged to a small employer if the commission percentage is based on  
33 all premiums paid by the small employer. (V.T.I.C. Art. 26.73,  
34 Subsecs. (a), (c), (d).)

35 Source Law

36 Art. 26.73. (a) A small employer carrier shall  
37 pay the same commission, percentage of premium or  
38 other amount to an agent for renewal of a small  
39 employer health benefit plan as the carrier paid for

1 original placement of the plan. Compensation for  
2 renewal of a plan may be adjusted upward to reflect an  
3 increase in the cost of living or similar factors.

4 (c) A small employer carrier may not implement,  
5 directly or indirectly, agent commission schedules  
6 that vary the level of agent commissions based on the  
7 size of the group, or otherwise reduce access to small  
8 employer health benefit plans.

9 (d) Notwithstanding Subsection (c) of this  
10 article, a small employer carrier may:

11 (1) vary agent commission amounts or  
12 percentages based on group size if the variation in  
13 the commission amounts or percentages are inversely  
14 related to the size of the group;

15 (2) vary agent commission amounts or  
16 percentages based on the cumulative premium paid by a  
17 single small employer over a specific period if the  
18 variation in the commission amounts or percentages are  
19 inversely related to the cumulative premium paid  
20 during the period; or

21 (3) pay agent commissions as a percentage  
22 of premium charged to a small employer if the  
23 commission percentage is based on all premium paid by  
24 the small employer.

#### 25 Revised Law

26 Sec. 1501.354. REQUIRED DISCLOSURES. (a) In connection  
27 with offering a small employer health benefit plan for sale, each  
28 small employer health benefit plan issuer and agent shall make a  
29 reasonable disclosure, as part of its solicitation and sales  
30 materials, of:

31 (1) the extent to which premium rates for a specific  
32 small employer are established or adjusted based on the actual or  
33 expected variation in:

34 (A) claim costs; or

35 (B) health status of the employer's employees and  
36 their dependents;

37 (2) provisions concerning the issuer's right to change  
38 premium rates and factors other than claims experience that affect  
39 changes in premium rates;

40 (3) provisions relating to renewability of policies  
41 and contracts; and

42 (4) any preexisting condition provisions.

43 (b) On request by a small employer, each small employer  
44 health benefit plan issuer shall disclose the benefits and premiums  
45 available under all small employer coverage for which the employer

1 is qualified.

2 (c) A small employer health benefit plan issuer is not  
3 required to disclose information to a small employer that is  
4 proprietary or trade secret information under applicable law.

5 (d) Information provided under this section to a small  
6 employer must be provided in a manner that is:

7 (1) understandable by the average small employer; and

8 (2) sufficient to reasonably inform a small employer  
9 of its rights and obligations under a small employer health benefit  
10 plan. (V.T.I.C. Art. 26.40.)

11 Source Law

12 Art. 26.40. (a) In connection with the  
13 offering for sale of any small employer health benefit  
14 plan, each small employer carrier and each agent shall  
15 make a reasonable disclosure, as part of its  
16 solicitation and sales materials, of:

17 (1) the extent to which premium rates for a  
18 specific small employer are established or adjusted  
19 based on the actual or expected variation in claim  
20 costs or the actual or expected variation in health  
21 status of the employees of the small employer and their  
22 dependents;

23 (2) provisions concerning the small  
24 employer carrier's right to change premium rates and  
25 the factors other than claim experience that affect  
26 changes in premium rates;

27 (3) provisions relating to renewability of  
28 policies and contracts; and

29 (4) any preexisting condition provision.

30 (b) Each small employer carrier shall disclose  
31 on request by a small employer the benefits and  
32 premiums available under all small employer coverage  
33 for which the employer is qualified.

34 (c) A small employer carrier is not required to  
35 disclose any information to a small employer that is  
36 proprietary or trade secret information under  
37 applicable law.

38 (d) Information provided under this article to  
39 small employers must be provided in a manner that is  
40 understandable by the average small employer and  
41 sufficient to reasonably inform small employers of  
42 their rights and obligations under a small employer  
43 health benefit plan.

44 Revised Law

45 Sec. 1501.355. RULES CONCERNING MARKETING AND  
46 AVAILABILITY. Rules adopted under Section 1501.010 may establish  
47 additional standards to provide for the fair marketing and broad  
48 availability of small employer health benefit plans to small  
49 employers in this state. (V.T.I.C. Art. 26.75.)

1                                    Source Law

2                    Art. 26.75.    The commissioner may adopt rules  
3                    setting forth additional standards to provide for the  
4                    fair marketing and broad availability of small  
5                    employer health benefit plans to small employers in  
6                    this state.

7                                    Revisor's Note

8                    V.T.I.C.    Article    26.75    provides    that    the  
9                    commissioner of insurance "may adopt rules setting  
10                  forth additional standards to provide for the fair  
11                  marketing and broad availability of small employer  
12                  health benefit plans."    The revised law omits the  
13                  portion of Article 26.75 authorizing the adoption of  
14                  rules and substitutes a reference to Section 1501.010  
15                  for the reason stated in Revisor's Note (2) to Section  
16                  1501.211.

17                                  Revised Law

18                  Sec. 1501.356.    REPORTING    REQUIREMENTS.        (a)        In    this  
19                  section, "case characteristics" has the meaning assigned by Section  
20                  1501.201.

21                  (b)    The department may require periodic reports by small  
22                  employer health benefit plan issuers and agents regarding small  
23                  employer health benefit plans issued by those issuers and agents.  
24                  The reporting requirements must include information regarding:

- 25                                  (1)    case characteristics; and  
26                                  (2)    the number of small employer health benefit plans  
27                  in various categories that are marketed or issued to small  
28                  employers. (V.T.I.C. Art. 26.71, Subsec. (b).)

29                                  Source Law

30                                  (b)    The department may require periodic reports  
31                                  by small employer carriers and agents regarding small  
32                                  employer health benefit plans issued by those carriers  
33                                  and agents.    The reporting requirements shall include  
34                                  information regarding case characteristics and the  
35                                  numbers of small employer health benefit plans in  
36                                  various categories that are marketed or issued to  
37                                  small employers.

38                                  Revised Law

39                  Sec. 1501.357.    VIOLATIONS.    A    violation        of        Section  
40                  1501.352 by a small employer health benefit plan issuer or agent is

1 an unfair method of competition and an unfair or deceptive act or  
2 practice under Chapter 541. (V.T.I.C. Art. 26.76, Subsec. (a).)

3 Source Law

4 Art. 26.76. (a) A violation of Article 26.72  
5 of this code by a small employer carrier or an agent is  
6 an unfair method of competition and an unfair or  
7 deceptive act or practice under Article 21.21 of this  
8 code.

9 Revised Law

10 Sec. 1501.358. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR.  
11 If a small employer health benefit plan issuer enters into an  
12 agreement with a third-party administrator to provide  
13 administrative, marketing, or other services related to offering  
14 small employer health benefit plans to small employers in this  
15 state, the third-party administrator is subject to Sections  
16 1501.111, 1501.351-1501.353, and 1501.355-1501.357. (V.T.I.C.  
17 Art. 26.76, Subsec. (b).)

18 Source Law

19 (b) If a small employer carrier enters into an  
20 agreement with a third-party administrator to provide  
21 administrative, marketing, or other services related  
22 to the offering of small employer health benefit plans  
23 to small employers in this state, the third-party  
24 administrator is subject to this subchapter.

25 [Subchapters I-L reserved for expansion]

26 SUBCHAPTER M. LARGE EMPLOYER HEALTH BENEFIT PLANS

27 Revised Law

28 Sec. 1501.601. PARTICIPATION CRITERIA. (a) In this  
29 subchapter, "participation criteria" means any criteria or rules  
30 established by a large employer to determine the employees who are  
31 eligible for enrollment or continued enrollment under the terms of  
32 a health benefit plan.

33 (b) The participation criteria may not be based on health  
34 status related factors. (V.T.I.C. Art. 26.02, Subdiv. (20);  
35 Art. 26.83, Subsec. (a) (part).)

36 Source Law

37 Art. 26.02. In this chapter:

38 (20) "Participation criteria" means any  
39 criteria or rules established by a large employer to

1 determine the employees who are eligible for  
2 enrollment, including continued enrollment, under the  
3 terms of a health benefit plan. Such criteria or rules  
4 may not be based on health status related factors.

5 Art. 26.83. (a) . . . The participation  
6 criteria may not be based on health status related  
7 factors.

8 Revised Law

9 Sec. 1501.602. COVERAGE REQUIREMENTS. (a) A large  
10 employer health benefit plan issuer:

11 (1) may refuse to provide coverage to a large employer  
12 in accordance with the issuer's underwriting standards and  
13 criteria;

14 (2) shall accept or reject the entire group of  
15 individuals who meet the participation criteria and choose  
16 coverage; and

17 (3) may exclude only those employees or dependents who  
18 decline coverage.

19 (b) On issuance of a health benefit plan to a large  
20 employer, a large employer health benefit plan issuer shall provide  
21 coverage to the employees who meet the participation criteria  
22 without regard to an individual's health status related factors.

23 (V.T.I.C. Art. 26.83, Subsecs. (a) (part), (b) (part).)

24 Source Law

25 Art. 26.83. (a) A large employer carrier may  
26 refuse to provide coverage to a large employer in  
27 accordance with the carrier's underwriting standards  
28 and criteria. However, on issuance of a health benefit  
29 plan to a large employer, each large employer carrier  
30 shall provide coverage to the employees who meet the  
31 participation criteria established by the large  
32 employer without regard to an individual's health  
33 status related factors. . . .

34 (b) The large employer carrier shall accept or  
35 reject the entire group of individuals who meet the  
36 participation criteria established by the employer and  
37 who choose coverage and may exclude only those  
38 employees or dependents who have declined  
39 coverage. . . .

40 Revisor's Note

41 Subsection (a), V.T.I.C. Article 26.83, requires  
42 a large employer carrier to provide coverage under a  
43 large employer health benefit plan to "the employees  
44 who meet the participation criteria established by the

1 large employer." Subsection (b), V.T.I.C. Article  
2 26.83, requires a large employer carrier to "accept or  
3 reject the entire group of individuals who meet the  
4 participation criteria established by the employer."  
5 Throughout this subchapter, the revised law omits  
6 references to the establishment of participation  
7 criteria by an employer as unnecessary. Subdivision  
8 (20), V.T.I.C. Article 26.02, revised as Section  
9 1501.601, defines "participation criteria" to mean  
10 "criteria or rules established by a large employer."

11 Revised Law

12 Sec. 1501.603. EXCLUSION OF ELIGIBLE EMPLOYEE OR DEPENDENT  
13 PROHIBITED. A large employer health benefit plan issuer may not  
14 exclude an employee who meets the participation criteria or an  
15 eligible dependent, including a late enrollee, who would otherwise  
16 be covered under a large employer group. (V.T.I.C. Art. 26.83,  
17 Subsec. (1).)

18 Source Law

19 (1) A large employer carrier may not exclude any  
20 employee who meets the participation criteria or an  
21 eligible dependent, including a late enrollee, who  
22 would otherwise be covered under a large employer  
23 group.

24 Revised Law

25 Sec. 1501.604. DECLINING COVERAGE. (a) A large employer  
26 health benefit plan issuer shall obtain a written waiver from each  
27 employee who meets the participation criteria and declines coverage  
28 under a health benefit plan offered to a large employer. The waiver  
29 must ensure that the employee was not induced or pressured to  
30 decline coverage because of the employee's health status related  
31 factors.

32 (b) A large employer health benefit plan issuer may not  
33 provide coverage to a large employer or the employer's employees if  
34 the issuer or an agent for the issuer knows that the employer has  
35 induced or pressured an employee who meets the participation  
36 criteria or a dependent of the employee to decline coverage because

1 of the individual's health status related factors. (V.T.I.C. Art.  
2 26.83, Subsecs. (c), (d).)

3 Source Law

4 (c) The large employer carrier shall obtain a  
5 written waiver for each employee who meets the  
6 participation criteria and who declines coverage under  
7 the health plan offered to a large employer. The  
8 waiver must ensure that the employee was not induced or  
9 pressured into declining coverage because of the  
10 employee's health status related factors.

11 (d) A large employer carrier may not provide  
12 coverage to a large employer or the employees of a  
13 large employer if the carrier or an agent for the  
14 carrier knows that the large employer has induced or  
15 pressured an employee who meets the participation  
16 criteria or a dependent of the employee to decline  
17 coverage because of that individual's health status  
18 related factors.

19 Revised Law

20 Sec. 1501.605. MINIMUM CONTRIBUTION OR PARTICIPATION  
21 REQUIREMENTS. (a) A large employer health benefit plan issuer  
22 may require a large employer to meet a minimum contribution or  
23 participation requirement as a condition of issuance or renewal in  
24 accordance with the issuer's usual and customary practices for all  
25 the issuer's employer health benefit plans in this state.

26 (b) A participation requirement may determine the  
27 percentage of eligible employees who meet the participation  
28 criteria and who must be enrolled in the health benefit plan.

29 (c) A large employer health benefit plan issuer may apply a  
30 participation requirement to a large employer's eligible  
31 employees, but may not apply the requirement to eligible dependents  
32 of those employees.

33 (d) A participation requirement must be stated in the health  
34 benefit plan contract and must be applied uniformly to each large  
35 employer offered or issued coverage by a large employer health  
36 benefit plan issuer in this state. (V.T.I.C. Art. 26.83, Subsec.  
37 (e).)

38 Source Law

39 (e) A large employer carrier may require a large  
40 employer to meet minimum contribution or participation  
41 requirements as a condition of issuance and renewal in  
42 accordance with the carrier's usual and customary  
43 practices for all employer health benefit plans in

this state. The participation requirements may determine the percentage of eligible employees who meet the participation criteria established by the employer who must be enrolled in the plan. A large employer carrier may apply participation requirements to the employer's eligible employees, but may not apply those requirements to eligible dependents. Those requirements must be stated in the contract and must be applied uniformly to each large employer offered or issued coverage by the large employer carrier in this state.

Revised Law

Sec. 1501.606. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a) The initial enrollment period for employees meeting the participation criteria under a large employer health benefit plan must be at least 31 days, with a 31-day annual open enrollment period.

(b) A large employer may establish a waiting period. The employer shall determine the duration of the waiting period.

(c) A new employee who meets the participation criteria may not be denied coverage if the application for coverage is received by the large employer not later than the 31st day after the later of:

(1) the date employment begins; or

(2) the date the waiting period established under Subsection (b) expires.

(d) If dependent coverage is offered to the enrollees under a large employer health benefit plan:

(1) the initial enrollment period for the dependents must be at least 31 days, with a 31-day annual open enrollment period; and

(2) a dependent of a new employee who meets the participation criteria may not be denied coverage if the application for coverage is received by the large employer not later than the 31st day after the latest of:

(A) the date on which the employment begins;

(B) the date the waiting period established under Subsection (b) expires; or

(C) the date the dependent becomes eligible for

1 enrollment.

2 (e) A late enrollee may be excluded from coverage until the  
3 next annual open enrollment period and may be subject to a one-year  
4 preexisting condition provision as described by Section 1501.102.  
5 The period during which a preexisting condition provision applies  
6 may not exceed 18 months from the date of the initial application.  
7 (V.T.I.C. Art. 26.83, Subsecs. (f), (g), (h), (i), (j), (k).)

8 Source Law

9 (f) The initial enrollment period for employees  
10 meeting the participation criteria must be at least 31  
11 days, with a 31-day annual open enrollment period.

12 (g) If dependent coverage is offered to  
13 enrollees under a large employer health benefit plan,  
14 the initial enrollment period for the dependents must  
15 be at least 31 days, with a 31-day annual open  
16 enrollment period.

17 (h) A large employer may establish a waiting  
18 period during which a new employee is not eligible for  
19 coverage. The employer shall determine the duration  
20 of the waiting period.

21 (i) A new employee who meets the participation  
22 criteria of a covered large employer may not be denied  
23 coverage if the application for coverage is received  
24 by the large employer not later than the 31st day after  
25 the later of:

26 (1) the date on which the employment  
27 begins; or

28 (2) the date on which the waiting period  
29 established under Subsection (h) of this article  
30 expires.

31 (j) If dependent coverage is offered to the  
32 enrollees under a large employer health benefit plan,  
33 a dependent of a new employee who meets the  
34 participation criteria established by the large  
35 employer may not be denied coverage if the application  
36 for coverage is received by the large employer not  
37 later than the 31st day after the later of:

38 (1) the date on which the employment  
39 begins;

40 (2) the date on which the waiting period  
41 established under Subsection (h) of this article  
42 expires; or

43 (3) the date on which the dependent  
44 becomes eligible for enrollment.

45 (k) A late enrollee may be excluded from  
46 coverage until the next annual open enrollment period  
47 and may be subject to a 12-month preexisting condition  
48 provision as described by Article 26.90 of this code.  
49 The period during which a preexisting condition  
50 provision applies may not exceed 18 months from the  
51 date of the initial application.

52 Revisor's Note

53 Subsection (h), V.T.I.C. Article 26.83, provides  
54 that a large employer may establish a waiting period  
55 "during which a new employee is not eligible for

1 coverage." The revised law omits the quoted language  
2 for the reason stated in the revisor's note to Section  
3 1501.156.

4 Revised Law

5 Sec. 1501.607. COVERAGE FOR NEWBORN CHILDREN. (a) A  
6 large employer health benefit plan may not limit or exclude initial  
7 coverage of a newborn child of a covered employee.

8 (b) Coverage of a newborn child of a covered employee under  
9 this section ends on the 32nd day after the date of the child's  
10 birth unless:

11 (1) children are eligible for coverage under the large  
12 employer health benefit plan; and

13 (2) not later than the 31st day after the date of  
14 birth, the large employer health benefit plan issuer receives:

15 (A) notice of the birth; and

16 (B) any required additional premium. (V.T.I.C.  
17 Art. 26.84, Subsec. (a).)

18 Source Law

19 Art. 26.84. (a) A large employer health  
20 benefit plan may not limit or exclude initial coverage  
21 of a newborn child of a covered employee. Any coverage  
22 of a newborn child of a covered employee under this  
23 subsection terminates on the 32nd day after the date of  
24 the birth of the child unless:

25 (1) children are eligible for coverage  
26 under the large employer health benefit plan; and

27 (2) notification of the birth and any  
28 required additional premium are received by the large  
29 employer carrier not later than the 31st day after the  
30 date of birth.

31 Revised Law

32 Sec. 1501.608. COVERAGE FOR ADOPTED CHILDREN. (a) This  
33 section applies only if children are eligible for coverage under a  
34 large employer health benefit plan.

35 (b) A large employer health benefit plan may not limit or  
36 exclude initial coverage of an adopted child of an insured. A child  
37 is considered to be the adopted child of an insured if the insured  
38 is a party to a suit in which the insured seeks to adopt the child.

39 (c) An adopted child of an insured may be enrolled, at the

1 insured's option, not later than the 31st day after:

2 (1) the date the insured becomes a party to a suit in  
3 which the insured seeks to adopt the child; or

4 (2) the date the adoption becomes final.

5 (d) Coverage of an adopted child of an insured under this  
6 section ends unless the large employer health benefit plan issuer  
7 receives notice of the adoption and any required additional premium  
8 not later than the 31st day after:

9 (1) the date the insured becomes a party to a suit in  
10 which the insured seeks to adopt the child; or

11 (2) the date the adoption becomes final. (V.T.I.C.  
12 Art. 26.84, Subsecs. (b), (c), (d).)

13 Source Law

14 (b) If children are eligible for coverage under  
15 the large employer health benefit plan, a large  
16 employer health benefit plan may not limit or exclude  
17 initial coverage of an adopted child of an insured. A  
18 child is considered to be the child of an insured if  
19 the insured is a party in a suit in which the adoption  
20 of the child by the insured is sought.

21 (c) If children are eligible for coverage under  
22 the large employer health benefit plan an adopted  
23 child of an insured may be enrolled, at the option of  
24 the insured, within either:

25 (1) 31 days after the insured is a party in  
26 a suit for adoption; or

27 (2) 31 days of the date the adoption is  
28 final.

29 (d) Coverage of an adopted child of an employee  
30 under this article terminates unless notification of  
31 the adoption and any required additional premiums are  
32 received by the large employer carrier not later than  
33 either:

34 (1) the 31st day after the insured becomes  
35 a party in a suit in which the adoption of the child by  
36 the insured is sought; or

37 (2) the 31st day after the date of the  
38 adoption.

39 Revised Law

40 Sec. 1501.609. COVERAGE FOR UNMARRIED CHILDREN. (a) This  
41 section applies only if children are eligible for coverage under a  
42 large employer health benefit plan.

43 (b) Any limiting age applicable under a large employer  
44 health benefit plan to an unmarried child of an enrollee is 25 years  
45 of age. (V.T.I.C. Art. 26.84, Subsec. (e).)

Source Law

(e) If children are eligible for coverage under the terms of a large employer health benefit plan, any limiting age applicable to an unmarried child of an enrollee is 25 years of age.

Revised Law

Sec. 1501.610. PREMIUM RATES; ADJUSTMENTS. (a) A large employer health benefit plan issuer may charge premiums in accordance with this section to the group of employees or dependents who meet the participation criteria and do not decline coverage.

(b) A large employer health benefit plan issuer may not charge an adjustment to premium rates for individual employees or dependents for health status related factors or duration of coverage. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of employees of a large employer.

(c) Subsection (b) does not restrict the amount that a large employer may be charged for coverage. (V.T.I.C. Art. 26.83, Subsec. (b) (part); Art. 26.89, Subsec. (a).)

## Source Law

[Art. 26.83]

(b) . . . The carrier may charge premiums in accordance with Article 26.89 of this code to the group of employees or dependents who meet the participation criteria established by the employer and who do not decline coverage.

Art. 26.89. (a) A large employer carrier may not charge an adjustment to premium rates for individual employees or dependents for health status related factors or duration of coverage. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of employees of the large employer. This subsection does not restrict the amount that a large employer may be charged for coverage.

## Revised Law

Sec. 1501.611. MARKETING REQUIREMENTS. On request, each large employer purchasing a health benefit plan shall be given a summary of all plans for which the employer is eligible. (V.T.I.C. Art. 26.91, Subsec. (a).)

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Art. 26.91. (a) On request, each large employer purchasing health benefit plans shall be given a summary of all plans for which the employer is eligible.

## Revised Law

Sec. 1501.612. ENCOURAGING EXCLUSION OF EMPLOYEE PROHIBITED. A large employer health benefit plan issuer or agent may not encourage a large employer to exclude an employee who meets the participation criteria from health coverage provided in connection with the employee's employment. (V.T.I.C. Art. 26.92.)

## Source Law

Art. 26.92. A large employer carrier or agent may not encourage a large employer to exclude an employee, meeting the participation criteria, from health coverage provided in connection with the employee's employment.

## Revised Law

Sec. 1501.613. AGENTS. A large employer health benefit plan issuer may not terminate, fail to renew, or limit its contract or agreement of representation with an agent because of health status related factors of a large employer group placed by the agent with the issuer. (V.T.I.C. Art. 26.93.)

## Source Law

Art. 26.93. A large employer carrier may not terminate, fail to renew, or limit its contract or agreement of representation with an agent because of any health status related factors of a large employer group placed by the agent with the carrier.

## Revised Law

Sec. 1501.614. REPORTING OF CLAIMS INFORMATION. (a) This section applies only to an insured employer health benefit plan.

(b) An employer carrier, on written request from an insured employer covered by that carrier, shall report to the employer information from the 12 months preceding the date of the report regarding:

(1) the total amount of charges submitted to the carrier for persons covered under the employer health benefit plan;

(2) the total amount of payments made by the carrier to health care providers for persons covered under the plan; and

1           (3) to the extent available, information on claims  
2 paid by type of health care provider, including total hospital  
3 charges, physician charges, pharmaceutical charges, and other  
4 charges.

5           (c) An employer carrier shall provide information requested  
6 by an employer under this section annually not later than the 30th  
7 day before the anniversary or renewal date of the employer's health  
8 benefit plan.

9           (d) Notwithstanding Subsection (c), an employer carrier is  
10 not required to provide information under Subsection (b) earlier  
11 than the 30th day after the date of the initial written request.

12           (e) An employer carrier may not report any information  
13 required under this section if the release of the information is  
14 prohibited by federal law or regulation.

15           (f) An employer carrier shall provide claim information  
16 under this section in the aggregate, without information through  
17 which a specific individual covered by the health insurance or  
18 evidence of coverage may be identified. (V.T.I.C. Art. 26.96.)

19                           Source Law

20           Art. 26.96. (a) This article applies only to  
21 an insured employer health benefit plan.

22           (b) An employer carrier, on written request from  
23 an insured employer covered by that carrier, shall  
24 report to the employer information from the 12 months  
25 preceding the date of the report regarding:

26                   (1) the total amount of charges submitted  
27 to the carrier for persons covered under the employer  
28 health benefit plan;

29                   (2) the total amount of payments made by  
30 the carrier to health care providers for persons  
31 covered under the plan; and

32                   (3) to the extent available, information  
33 on claims paid by type of health care provider,  
34 including the total hospital charges, physician  
35 charges, pharmaceutical charges, and other charges.

36           (c) An employer carrier shall provide  
37 information requested by an employer under this  
38 article annually not later than the 30th day before the  
39 anniversary or renewal date of the employer's health  
40 benefit plan.

41           (d) Notwithstanding Subsection (c) of this  
42 article, an employer is not required to provide  
43 information under Subsection (b) of this article  
44 earlier than the 30th day after the date of the initial  
45 written request.

46           (e) An employer carrier may not report any  
47 information required under this article the release of  
48 which is prohibited by federal law or regulation.

1 (f) Claim information provided by an employer  
2 carrier under this section shall be provided in the  
3 aggregate, without information through which a  
4 specific individual covered by the health insurance or  
5 evidence of coverage may be identified.

6 Revised Law

7 Sec. 1501.615. ADDITIONAL REPORTING REQUIREMENTS. The  
8 department may require periodic reports by large employer health  
9 benefit plan issuers and agents regarding the large employer health  
10 benefit plans issued by those issuers. The reporting requirements  
11 must:

12 (1) require information regarding the number of plans  
13 in various categories that are marketed or issued to large  
14 employers; and

15 (2) comply with federal law, including regulations.  
16 (V.T.I.C. Art. 26.91, Subsec. (b).)

17 Source Law

18 (b) The department may require periodic reports  
19 by large employer carriers and agents regarding the  
20 large employer health benefit plans issued by those  
21 carriers. The reporting requirements must require  
22 information regarding the number of large employer  
23 health benefit plans in various categories that are  
24 marketed or issued to large employers and must comply  
25 with federal law and regulations.

26 Revised Law

27 Sec. 1501.616. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR.  
28 If a large employer health benefit plan issuer enters into an  
29 agreement with a third-party administrator to provide  
30 administrative, marketing, or other services related to offering  
31 large employer health benefit plans to large employers in this  
32 state, the third-party administrator is subject to this subchapter  
33 and Subchapter C. (V.T.I.C. Art. 26.95.)

34 Source Law

35 Art. 26.95. If a large employer carrier enters  
36 into an agreement with a third-party administrator to  
37 provide administrative, marketing, or other services  
38 related to the offering of large employer health  
39 benefit plans to large employers in this state, the  
40 third-party administrator is subject to this  
41 subchapter.

42 CHAPTER 1502. HEALTH BENEFIT PLANS FOR CHILDREN

43 SUBCHAPTER A. GENERAL PROVISIONS